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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Understanding a troubled child, as this teacher is obviously attempting to do, may be the first step toward helping the child overcome blocks to learning. How a psychiatrically oriented clinical team is working with groups of teachers to increase the understanding of both teachers and clinicians of the factors that affect children's performance and behavior in school is described in the article beginning on page 19.

children

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At first glance, few groups seem more dissimilar than the talented, privileged student who attend residential liberal arts college and the unwanted or neglected children who live in group residential centers. Yet behind the real differences in age and social privilege that separate these two groups, there are profound similarities in their situations. Essentially the same issues arise in planning for what one college dean calls "the care and feeding of college students" as in planning for the group residential care of children.

As Erving Goffman has pointed out, there are few institutions in modern society that may encompass practically all aspects of a person's life. He calls these "total institutions,"¹ for in them residential life, social life, and work life are combined—often within the same walls, certainly within the same institutional framework. As examples he cites merchant ships, military services, mental hospitals, prisons, monasteries, and residential treatment institutions. He might also have cited institutions for neglected and dependent children.

This concept of "total institution" becomes more useful if we distinguish between different kinds of total institutions. There are three types: (1) those institutions that could be called *instrumental* because they are trying to get a job done in the outside world—for instance, a merchant ship carrying cargo across the sea; (2) those institutions whose purpose is at least nominally *therapeutic*, preventative or corrective, such as a prison or mental hospital; and (3) a small group of institutions whose explicit purpose is *developmental*, such as a residential college, a boarding school, or a residential center for neglected and dependent children.

A residential college, of course, is less "total" than an army or a prison: Students are on the whole free to enter and leave at will. But for most college students, during the academic year at least, their lives are embodied and to some extent regulated within a single framework and a set of walls. And obviously, group residential centers for children are total institutions in the full sense of the word.

Developmental institutions, whether colleges or children's "homes," have a number of common characteristics. For one, they at least nominally accept as their primary objective the promotion of the "normal" or optimal development of their charges, the residents. They therefore usually try to ally themselves with what they take to be the natural force for growth and development in the individual. They see their task as somehow stimulating, support

**COLLEGE
STUDENTS
AND
CHILDREN
IN**

developmental institutions

KENNETH KENISTON

g, and confirming the development of each resident. In this respect they differ sharply from an institutionalization like an army or a merchant ship, which may ignore or even impede the individual's overall development. And they also differ from therapeutic institutions like good mental hospitals, which have as a primary task to intervene and correct faulty development. This does not mean that developmental institutions like colleges or institutions for children do not have ways of correcting faulty development. But, on the whole, their goals are not so much to correct failures as to promote normal, healthy growth.

A second characteristic of developmental institutions is that they exercise quasi-familial functions. Ordinarily, such institutions arise in situations where families cannot or are thought not to be able to do an adequate job. A children's institution, for example, usually enters the picture when there is no family that can take care of the child, or when the child's actual family is exerting a destructive influence on his development. Boarding schools and residential colleges generally arise because individual families cannot provide the kind of "character-building," intellectual stimulation, or environmental enrichment provided by a residential school. This does not mean that developmental institutions should think of themselves as families, for they can never perform all the functions of a family.

Many of the same kinds of practical and theoretical

problems arise in all developmental institutions, whether they are dealing with adolescents and young adults or with infants and young children. Some of these problems were underscored in two studies with which I have recently been involved. One of these was a study of "alienated" college students—a small group of students who were extreme in their rejection of what they took to be the dominant values and roles of institutions in American society. The second is an ongoing study of gifted students who drop out of college.

The psychology of alienation

For about 6 years, I was involved in the study of alienated undergraduates at Harvard University. The initial research consisted chiefly of objective tests—the systematic comparison of alienated and nonalienated students through the use of questionnaires. Almost 2,000 students were involved, but although these statistical studies yielded useful information, they did not take me very far toward the question I was trying to answer: Why is it that some students are alienated whereas others are not?

To try to answer this question I turned to a more intensive study of 12 students who had been selected because of the extreme degree of their alienation as measured by questionnaires. This group was contrasted with another group of the same size at the opposite pole—"extremely unalienated"—and with a third control group that was not extreme in either way. All three groups were studied over the last 3 years of their college careers.

Each student spent altogether about 200 hours par-

sed on a talk given at the Workshop on Group Residential
re of Infants and Young Children, New Haven, Conn.,
ril 1966.

ticipating in the research. Each was interviewed about his views of the world, his current behavior, and his life history, and each took part in a large number of psychological experiments.

A comparison of the data from the alienated group with that from the other two groups revealed a number of distinctive patterns of ideology, behavior, life history, and fantasy among the alienated students. In addition to being alienated from American culture, they were on the whole pessimistic, distrustful, resentful, and cynical about human nature. They saw themselves as outsiders whose isolation and aloneness was part of the human condition, not their own personal problem. To them, the universe seemed a formless and unstructured chaos lacking in meaning and purpose. And they rejected all cooperative group endeavors on the grounds that conformity means the destruction of individuality.

Most of these students came from a similar family constellation. Characteristically, they described their mothers as magnetic, emotional, passionate, and attractive women to whom they, the sons, were extremely, often excessively, close. At the same time they described their mothers as possessive, confining, restrictive, nagging, and intrusive.

About their fathers, these alienated students volunteered very little information. When pressed to discuss their fathers, they described them as disappointed, frustrated, detached, outwardly cold men. However, the alienated students usually imagined that their fathers had, at one point in their own youth, possessed considerable imagination, idealism, and fire, which had been lost in adulthood. So the father, as the son saw him, was a man deeply disappointed by his own failure to realize his youthful dreams.

Such a family constellation, we felt, had obvious relationships to the development of alienation. Seeing their fathers as men who had been broken by life or by their marriages and thus defeated by "the American way of life," these students were determined not to let what happened to their fathers happen to them. In rejecting their fathers, they also felt it necessary to reject the society that, as they saw it, had ruined their fathers. In other words, from their fathers these students had derived an image of conventional masculine adulthood that was repugnant to them, so they spurned conventional adulthood in American society.²

In further explaining the alienation of these students, I should point out that Harvard undergraduates tend to be somewhat more alienated as seniors

than as freshmen, although rarely to the extreme that these students reached. In addition, these students were on the whole an unusually imaginative, artistically oriented, and talented group of young men who argued that American society was in general not particularly hospitable to talented, creative persons. They were clearly reacting to the wider society as well as to their parents and family experiences.

Four major issues

When I discuss this material, I am often asked a number of related questions: Is alienation a kind of psychopathology? Why did the researchers not do more to cure these students of their alienation? Is it not a dreadful commentary on a college that its students become more alienated? Should the institution be doing something to change such students? Is alienation a good thing or a bad thing?

None of these questions can be answered simply. I mention them only because they point to two crucial issues that arise whenever we begin thinking about the development of a person in an institution.

1. What is "normal" development?

This first issue could be called the normative question—that is, the question of what kind of development the institution is trying to promote. Is the goal of a college, for example, to produce well-trained adults who will be able to fit smoothly into their positions in society? Or is it to promote critical intelligence and detachment from the immediate pressures and values of society? If we think that a smooth fit with society is the objective, then obviously a college that "alienates" its students from the prevailing society is a bad college. But if we think that critical intelligence and capacity for detachment from society is a good thing, then we may very well applaud a college that to some extent increases alienation in its students.

The normative question almost inevitably arises when one begins thinking about or planning an institutional framework that will encourage the "normal development" of the individual. Indeed, the terms "normal development" and "the optimal development of each individual" can be dangerous phrases since they may obscure the underlying value questions involved. We know that individuals can be stimulated to develop in a great variety of very different ways. But certain pathways to development may be mutually exclusive. For example, if a college tries to promote what some alumni groups call

loyalty and guts," it may be difficult for it also to promote such a quality as the critical use of intellect. Or in the case of small children, major emphasis on the group, as in the Israeli kibbutzim, may make it very difficult for a child to develop the intense attachment to a single mothering person that is characteristic of good family life in most Western societies.

It is not enough, then, to talk merely about "normal development" as the goal of a developmental institution. We know that parents have unconscious, preconscious, and conscious objectives in child rearing. They try to prevent Johnny from becoming like his alcoholic Uncle Harry; or to encourage Gertrude to become like her mother; or to develop orderliness, neatness, and parsimony in one child, or grace, freedom, agility, and imagination in another. The enormous variation in personalities produced by ordinary "healthy" families suggests that it is almost impossible not to stimulate certain developmental potentials and to inhibit or retard others.

But in a developmental institution, in contrast to a family, the normative question—what is "normal" development?—has to be made far more explicit and conscious in planning, programing, and evaluation. In these processes ethical questions cannot be avoided; they can only be evaded; and when they are evaded—when they are not openly faced and rationally considered—the results may be disastrous. For example, the way of characterizing those hygienic institutions whose toll on children's development has been so well documented³⁻⁵ is to note that they have answered the normative question with an unconscious decision to produce children who will be as little trouble as possible, a goal that can be reached only by sacrificing the child's individuality.

Some American colleges operate with a comparable unconscious goal—to keep their students out of trouble until they are old enough to enter the labor market. Fortunately, adolescents are more resilient and rebellious than infants and can sometimes overcome this kind of pressure. But the long-run con-

sequences of having this goal may be only slightly less deplorable than the consequences of having the goal of keeping children out of trouble in an anti-septic nursery. In children's institutions and in colleges alike, it is crucial to examine, reflect upon, and make explicit the specific developmental and educational objectives of the institution.

2. *For what kind of society?*

The second crucial issue raised by the study of alienated students is closely related to the first. It has to do with the nature of the society into which the developing individual will eventually move, and the demands, characteristics, and needs of that wider society. If, for example, it were clear that we lived in the best of all possible worlds, then alienation from our present society would definitely be an irrational and deplorable response. We would prescribe therapy for the alienated students and abolition or reform for "alienating" institutions. Or if we felt that criticism of society was always destructive, we should similarly deplore any degree of alienation.

In other words, any judgment as to the kind of human development we should ideally promote must be closely related to our picture of the nature of the wider society, of the demands it makes, and of its long-range needs. A developmental institution is preparing individuals for a particular society with special characteristics, pressures, and opportunities. It may be, for example, that certain kinds of child rearing will produce the kind of character structure and personality organization that is well suited to a Polynesian village but profoundly unsuited to American society. Or again, the kibbutz system of child rearing may produce the kind of adult who contributes a great deal to a kibbutz but one who would be unhappy and unproductive in American society.

Thus, in planning for the program or staffing of a developmental institution, we must consider the kind of society in which the "products" of the institution will live and their capacity for fulfillment and productivity in such a society. This does not mean that our goals should be to develop people who will unreflectively "adjust" to society. Obviously society needs social critics, independent thinkers, and even alienated men and women. But social critics also have to function within society.

Another study I have been involved in raises two more questions that are relevant to program planning in a developmental institution. This is an exploratory study of talented college dropouts. Every year hundreds of thousands of talented well-

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prepared young Americans drop out of colleges before graduating. We are trying to find out why. What does this mean in relation to the student's development? For whom is dropping out a progressive step, and for whom is it a regressive step?

This research at Yale University is in midstream. We are not even sure of all the questions we will ask, much less of the answers. But we are beginning to believe with Anna Freud that dropouts are people for whom the 4 years of college come at the worst possible time from a developmental point of view.⁶ They feel, consciously and unconsciously, that further psychological development is impossible as long as they remain within a collegiate setting; and in many or most cases, they are probably right. At least those who return (the majority) believe that their years away have enabled them to grow and mature, and the judgments of their friends and teachers usually confirm this belief.

In our exploratory clinical studies, we have found that dropouts often have difficult problems of identification with their parents, problems that seem to prevent that slow and gradual development of commitments and the consolidation of identity that usually take place in students of their age. And one reason why dropouts find these problems (which are, after all, universal) so difficult to resolve within a collegiate context has to do with their perceptions of the college environment.

Thus we find an almost universal but often unconscious tendency among these college dropouts to perceive the college as a whole as if it were a large-scale edition of their families. We have been repeatedly impressed with the striking parallel between dropouts' descriptions of the college and their descriptions of their parents. One sophomore, for example, was struggling with great problems of identification with a father who was overtly sadistic and brutal but who at the same time manifested through alcoholism an underlying passivity and dependency. This student describes the college as being authoritarian, harsh, and repressive, yet lacking in any real strength, decisiveness, or moral purpose. Another student, in the throes of attempting to reconcile conflicting identifications with warring parents, perceived the college as containing two conflicting sets of pressures, clearly identifiable with his parents.

This kind of "institutional transference"—equating the institution with the family—seems to be particularly widespread among students who drop out of college. Students who persist in college seem considerably less prone to identify college with their

parents. To be sure, they, too, tend to relate to the institution globally, almost as if it were a family. But for them the college is like a *new* family, a facilitating, liberating environment in which they can escape earlier family pressures and move forward in their development.

Another incidental finding of this study is how few colleges recognize the existence of dropouts. Of every 100 freshmen entering 4-year colleges in America, only 40 graduate from the same college 4 years later. Transfers and temporary or permanent interruptions of college are the rule rather than the exception. But most colleges keep few figures about "dropouts," ignore their existence, or with little factual basis treat them all as psychological "misfits" or academic "failures."

This study of dropouts underscores two further issues that arise in all developmental institutions

3. *What are the effects of the institution as a whole of its climate, culture, or morale, on the individual?*

In the end, we can no doubt analyze a student's perception of a college into a thousand component interpersonal relationships and experiences. But the student himself experiences the institution globally *as an entity*; and he tends to relate himself to it almost as if it were a single, crucial person in his life. This fact may help explain one of the puzzling results of many studies of college students. It has been shown again and again that probably the most potent factor in determining how colleges affect students' development is that intangible quality called "institutional morale," "college climate" or "campus culture." The effectiveness of an institution in promoting development seems more closely related to the characteristic of the institution as a whole than to any of its constituent parts—students, faculty, facilities, program, residential arrangements, or curriculum.

In many discussions of the relationship of the college to students' development, this quality of "climate" is neglected, perhaps because it is so difficult to define and measure precisely. We hear endless discussions of curriculum reform, promotion policies, admissions procedures, and residential facilities, but very few discussions of how to create or facilitate the right kind of "climate" or "morale." Yet even an unmotivated and unpromising student, if he is fortunate enough to enter a first-class college with very high institutional morale, may find himself caught up in a general tide of enthusiasm that pushes him to a height of personal and intellectual development that he never before dreamed of. On the other hand

ren a highly motivated freshman, if he enters an institution with low morale, may stagnate or regress. In young children the ability to relate to an institution as a whole is, of course, more limited than it is in adolescents. Nevertheless, in developmental institutions for young children, the climate of the institution as a whole may similarly be more important than any specific programs, staffing policies, or residential arrangements. It is conceivable, for example, that there may be institutions for children where the physical facilities are poor, where the staff philosophy is reactionary, and yet where—for reasons that we do not quite understand—children manage to flourish and grow. And it is also possible that there are institutions with advanced facilities and modern ideas about child development where for lack of a good “climate” somehow everything seems to go wrong, including the children’s development.

In thinking about how to create institutions that encourage human growth, we must recognize that individuals experience and respond to institutions as a whole, not only to their parts. We therefore need to plan not merely for programs, schedules, living arrangements, and so on, but also for how all of these variables might interact to produce the kind of staff morale, institutional climate, and intangible culture that nourishes healthy development.

4. *Can the institution deal realistically and supportively with individuals who are “deviant” or “atypical” in terms of its ideals and norms?*

All institutions, and especially developmental institutions, tend to have an implicit or explicit image of the “average expectable individual,” the “typical male man,” or the “normal child.” Procedures, programs, publicity, and even perceptions are organized around this image. At times in a college the image of “the typical student” is so powerful that it blinds administration and faculty to the fact that a majority of students in no way conform to this image.

Other developmental institutions also tend to develop systematic blind spots and irrational ways of responding to members who do not fit their definition of the “average expectable individual.” Sometimes the existence of person who do not fit the expected pattern of development is simply denied by a refusal to notice that they exist. Sometimes those whose development deviates from the expected are treated as misfits, failures, or malcontents. In either case, their lives are dominated by fear, shame, and a sense of their own inadequacy.

One of the marks of a superior developmental institution, whether a college or a residence for children, is its capacity both to recognize explicitly and support persons whose developmental needs and schedules deviate from the mythical or actual norm—without needing to relegate them to a limbo of abnormality, psychopathology, failure, or nonexistence. Those American colleges that clearly facilitate genuine intellectual and personal growth are noted for their emphasis on encouraging individuality and recognizing the special qualities of each student.

Such colleges tend to have flexible institutional programs, to apply their rules according to the individual’s needs and his development, and to be highly tolerant of dissent and deviance, both on campus and off. These colleges, and I suspect those children’s institutions that facilitate healthy personality growth, explicitly recognize that individual human beings have differing needs at different stages of development, that the rates and phases of normal human growth are highly variable, and that, in a sense, exceptional development is not the exception at all but the rule in human life.

In summary

Thus, despite the real differences between children in institutions and students in college, similar issues arise with regard to both groups. Both groups live in “developmental institutions” and the effectiveness of the institutions in promoting their growth depends in good part on how well these questions are answered: What is “normal” development? For what kind of society? What is the right “climate”? Can deviance be accepted? Planning, maintaining, or improving developmental institutions, therefore, demands not only attention to sound programing, staffing, and financing, but also a rational and informed examination of the underlying goals for its residents in the context of what is known about human development.

¹ Goffman, Erving: On the characteristics of total institutions. *In* Asylums: essays on the social situation of mental patients and other inmates. Anchor Publishing Co., Garden City, N.Y. 1961.

² Keniston, Kenneth: The uncommitted. Harcourt, Brace & World, Inc., New York. 1965.

³ Provence, Sally; Lipton, Rose C.: Infants in institutions. International Universities Press, New York. 1962.

⁴ Spitz, René A.: Hospitalism—an inquiry into the genesis of psychiatric condition in early childhood. *In* The psychoanalytic study of the child, vol. 1, 1945. International Universities Press, New York.

⁵ Bowlby, John: Maternal care and mental health. World Health Organization Technical Monograph Series No. 2. Geneva. 1951.

⁶ Group for the Advancement of Psychiatry: Sex and the college student. Atheneum Publishers, New York. 1966. P. 33.

FILIAL DEPRIVATION in PARENTS of children in foster care

SHIRLEY JENKINS

● One aftermath of the placement of children in foster care, the effects of maternal deprivation on the child, has been a subject for major research investigation. The reciprocal aspect of the placement transaction, "filial deprivation," or the separation experiences of the parent when the child enters foster care, however, has not been studied. In a society where the prevailing expectation is that parents will raise their own children, the failure to do so, with placement of progeny in settings outside their own homes under social agency care, is likely to have serious implications for the placing parents. How these feelings of separation from their children may affect mothers and fathers, and how their response patterns may be related to generalized attitudes of unworthiness or alienation are important questions. This paper reports on a beginning research effort to explore the concept of filial deprivation and to differentiate some of its dimensions by identifying feelings expressed by parents when their children enter foster care.

There are a number of reasons why clarification of the concept of filial deprivation is important to the better understanding of parent-child separation. When we consider the numbers of persons affected, the problem is of major proportions. There are over one-quarter of a million children in foster care in the United States at the present time, and any estimate of how many adults have at some time experienced separation from their children placed in foster care

under agency auspices would come to several million. The fact that the placement of children away from home also tends to involve a disproportionately high percentage of families who live in poverty, including many families of minority groups, raises the further question of whether this failure to meet society's expectations is interpreted by members of these groups as likely to lead to reprisals, such as abrogation of parental rights and the loss of decisionmaking power over the raising of their own children.

There is also the question of whether the way parents experience filial deprivation has predictive value in relation to the eventual return of the children to their own homes. It may be that part of the readjustment problem of foster children who go home reflects not only their own separation trauma, but also the reception they receive from their parents when they return. In some instances, the family may, in a sense, have closed in behind the separated child, so that there is neither psychological nor physical space for him when he returns home.

The setting for this research is the Columbia University School of Social Work, where a child welfare research program, directed by David Fanshel and supported by the Federal Children's Bureau, is undertaking a longitudinal study of 600 children from approximately 400 families who have entered social agency foster care in New York City in the calendar year 1966. The study sample is limited to children who are experiencing initial foster-care placement who have entered care before the age of 13 years, and who remain in care for a minimum of 90 days. These children will be studied from three angles: the child, his own family, and the agency which serves him.

Based on a paper presented at the 1966 annual meeting of the American Orthopsychiatric Association, San Francisco, Calif.

All children will be studied for a minimum of 5 years whether they remain in care or return home, and repeated measurements of child, family, and agency will be analyzed. These will include psychological testing and behavioral ratings of each child, and study of agency decisions and methods of care.

We expect the kind and degree of filial deprivation experienced in a family to be related to the problems that lead to foster care. A recently completed study by Jenkins and Sauber¹ revealed a variety of "main reasons" for placement. Of 425 families from which 891 children over 6 months old had been placed in care, from May through August 1963, as public charges in New York City, 29 percent had had the children placed because of the physical illness of an adult in the family; 11 percent, because of the mother's mental illness; 17 percent, because of the children's emotional or personality problems; 10 percent, because of severe parental neglect and abuse; and 33 percent, because of various other family problems, including parental incompetence, drug addiction, alcoholism, arrest, child abandonment, and unwillingness of caretakers other than parents to continue care.

In the majority of cases, the families were living in or on the edges of poverty and lacked supportive community services. Even in those cases in which the mother's institutionalization for mental illness was the main reason for placement, the interviews showed that the mother's mental breakdown was often associated with severe pressures from problems having to do with money, health, and housing. Data on parents' feelings associated with placement of their children must, therefore, be looked at in light of the factors causing stress in their families.

Review of the literature

The literature on maternal deprivation is singularly barren with regard to the feelings, reactions, and roles of parents when their children enter foster care. Bowlby in "Maternal Care and Mental Health" was chiefly concerned with the effect of severe deprivation on the emotional and personality growth of the child. He did, however, refer to the "vicious circle" resulting from unsympathetic handling by the mother when the returned child displays regressive, anxious behavior and note that "bad behavior" brings rebuffs and in turn rebuffs result in further "bad behavior."² In a review of the literature on maternal deprivation, Prugh and Harlow discuss "masked deprivation," in the parent and refer to what they

term "distorted relatedness" and "insufficient relatedness" on the part of parent to child. As an example of the latter, they report that "situational factors involving current reality problems may produce psychological disorders in the parent which may affect detrimentally the development processes of the infant."³

Some experimental studies of animal behavior contain observations that, although not immediately applicable to humans, raise some relevant questions about separation experiences. Blauvelt, for example, in her study, "Neonate-Mother Relationship in Goat and Man," describes how the mother goat establishes a territory, or safe area, near herself for her newborn kid. She suggests that when the separation of a mother goat and her newborn is achieved experimentally by introducing unexpected distracting or frightening stimuli, "if the mother and her newborn are not free to re-establish the normal pattern in the ways that are natural to them, it is possible that the mother animal will be unable to give the young the care essential for its survival at a later period."⁴

In describing readjustment problems of kittens after an experimental period of isolation from the mother cat, Rosenblatt, Turkewitz, and Schneirla note the changing patterns of mother-young relations in the litter period. They report: "... the litter situation confronting isolates returned from the brooder at different times differed radically from that prevalent at the earlier time of removal, especially as concerned the general behavior of the female [mother] and her responses to the kittens." The disturbed behavior in formerly isolated kittens returned to the litter was a result not of their experience in the brooder, but of their inability upon their return to make an appropriate adjustment to the changed pattern of the mother cat.⁵

In reporting on their studies of rhesus monkeys, Harlow and associates identify a point on a hypothetical graph of mother and infant contact needs where intensity is reversed and the infant's needs exceed the mother's. In an interpretation both alliterative and lyrical they say, "As attachment abates, ambivalence arises and anticipates alienation," and they go on to say:

From here on mother does not care
For baby fingers in her hair;
A touch that once went to her heart
Now merely makes the hair depart.⁶

The social work literature, like the separation material, stresses the child in placement, with concern being focused primarily on practical service prob-

lems and plans for care. Although a recent review of this literature conducted by students at the Columbia University School of Social Work⁷ did not reveal any systematic study of parental reactions to separation from their children, it did identify several references to feelings of parents when children are placed in foster care.

Aptekar, for example, in discussing casework with the child's own family, notes: "Every parent . . . reacts in his own individual way—with his own personality and in the context of his own living problems—to . . . the placement experience. All of his important problems and all of his chief character traits will come out in relation to the placement. . . ."⁸

In a discussion of casework techniques, Britton states: "In all cases where parents have failed to keep their children there is a tremendous sense of guilt which can be completely paralyzing. . . . The result of this feeling is apathy and depression or the projection of their feelings onto some external factor or person whom they feel to be to blame for what has happened. The sense of guilt and resulting hopelessness can be so great that they repudiate the relationship altogether and feel no sense of responsibility."⁹

According to Smith, Ricketts, and Smith, parents who were questioned in a child guidance clinic about their experiences on and after separation expressed some relief from tension, but also feelings of intense loneliness, emptiness, and guilt. One parent said that the child's placement felt "like a death."¹⁰

Young, in discussing separation, states that parents who fail become objects of scorn in the community since child rearing is a responsibility of parents in our culture and placement of a child away from home tends to be an admission that individuals have failed as parents.¹¹

Mandelbaum reports feelings of isolation, loneliness, and inadequacy in parents on placing children in residential treatment. He also reports that some parents expect punishment for having placed their children and express the fear that, when the children are grown and are "big and powerful," they will return to their homes to destroy their parents in retaliation for this wrong.¹²

These observations from the social work literature are interesting as points of reference, but their value is limited not only by a lack of systematic study, but also by the varying types of populations upon which they are based. The child welfare research program at Columbia University provides an opportunity for systematic access to a large sample and

wide range of placing parents, including many whose children have entered care precipitously with little or no parental planning and even in some cases without their knowledge. The design is comprehensive enough to secure data broad enough to derive generalizations useful to the child welfare field.

Instrument construction

As the task of instrument construction for the present study began, it was argued that it was too soon to study "filial deprivation" in itself, that the first problem was to explore the possibility of developing such a concept. A variety of ingenious ways of getting at this in what one psychologist has called "reverse clinical English" were considered and discarded. The investigators settled for a direct approach: After the interviewer identified the main problem that brought the child into care, the interviewer said—

We would like to understand more about how people feel when their children go into placement away from home. How about you, how did you feel the day your child was placed?

This request for the parents' immediate reaction on the day of placement produces baseline information for later discussion of changes in feelings.

After the parents give a general statement of their feelings at the time of placement, they are asked to describe in one of the following words their strongest feeling on that particular day: hurt; angry; relieved; nervous; ashamed; numb; sad; bitter; thankful; worried; guilty; empty. These words were obtained from 1-word summary statements from 14 exploratory interviews, used for developing a checklist for the final schedule.

For any of these feelings noted, parents are then asked to indicate intensity by choosing between "very" or "just a little." This is followed by an inquiry into the object of each feeling. If a person says he felt thankful, for example, he is then asked, for what?; "guilty," about what?; "angry," toward whom? In this way responses are developed in terms of the different dimensions of feelings expressed, including the nature of the feeling, the extent of the feeling, and the object of the feeling.

To make the data more concrete, parents are also asked to report their actions on the day the child was placed; who was told about the placement; and what reactions were expressed by others. To distinguish the reaction to the separation itself from their reaction to the placement situation, the parents are asked if they would have felt differently if the child

had remained at home in the care of a homemaker; if the child had been placed with a foster family rather than in an institution, or in an institution rather than a foster family; if the child had been cared for by relatives or friends rather than by a social agency. They are also asked whether their feelings about the children's placement reminded them of anything from their own childhood.

The parents are encouraged to discuss the changes in their feelings about separation as time went by in relation to changes in their social and family life, such as changes in living circumstances, new housing, new employment, or new friends. To determine whether the feelings they express are borne out by their actions, the interviewers ask specific questions such as, "If you have moved, do you have a place for the child to sleep?" and "What was done with your child's toys and clothes after he went into placement?" The parents are also asked to finish a series of eight incomplete sentences to determine whether responses to such a projective device can give clues to the emotional investment of the mother or father in the child. For example: "For a mother [or father] a child is ——." "Taking care of a child is ——." "How a child turns out depends on ——."

These questions about the parents' feelings of filial deprivation comprise only one of six major subject areas in the instrument for studying the family. The responses to them will be analyzed in relation to the other factors being studied, such as reason for placement, social attitudes, child-rearing attitudes, and socioeconomic circumstances. Other phases of the overall research program will also provide opportunity for validation of interview data. Agency reports on the child's behavior during placement, for example, and on the parents' care of and involvement with the child will be related to data obtained directly from the parents.

Some feeling patterns

Since the interviews with the families are still under way, analysis of the data from them will not be ready until the end of 1967. However, we have some clues about filial deprivation based on analysis of data from 27 individual interviews (14 exploratory and 13 pretest) and 3 group interviews with parents whose children are in foster care.

The first conclusion from this preliminary experience is that the analysis of parental feelings about separation will reveal rather than any ordinal scale of intensity clusters of related reactions depending

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on individual personality factors, the situation that precipitated placement, and the role of the child in the parent's life. Predominant feeling tones, however, did appear in individual cases. Interviewers commented on the "sad" or "glad" or "mad" or "scared" groups of reactions. In addition, the "nothing" group—absence of feeling—appeared to be another syndrome.

Some of the comments of parents are revealing of both personality and situation. An alcoholic mother said, "I was sad, I was hurt, I cried all the way home. Now I knew I would be alone." Her main wish was "to live until I am 50."

A mother whose children were placed for neglect because of a fire said, "I felt empty, numb, like the blackout, like everything was out of my hands. Now I would have to prove myself all over again." Her wish—nothing.

A father whose wife was hospitalized said, "I felt good, glad, relieved. Now I knew they would be taken care of until my wife gets well." His wish was for his wife to get out of the hospital.

A 15-year-old unmarried mother, with no place to keep her baby, was "angry, mad, upset, resentful." "It's my child," she said, "and all those big shot people were telling me what to do." Her wish—"that I hadn't become pregnant until I was 18 and knew how to manage."

Each parent made such a variety of responses to the checklist of feeling words that "ambivalence" might seem to be the predominant reaction. Reference to the object feeling, however, showed that the reactions were not as chaotic as they appeared. One mother, for example, reported that she was "hurt" by her social worker from the public child welfare agency; she was "angry" at the worker; she was "ashamed" at not being able to provide everything her son needed; she was "sad" about being away from her son; she was "bitter" toward the worker; she felt "guilty" for having fallen into a trap. Another mother whose placed child was emotionally disturbed said she was

"hurt" by the world; "angry" toward her son; "relieved" at not having to care for him; "sad" and "guilty" for being a poor mother.

One interesting finding is the number of mothers who reported that they "went home and went to sleep" immediately after the placement was made. Another was that parents who expressed a great deal of love and concern for their children frequently told of carefully retaining such reminders of them as a christening dress, a teddy bear, or toy soldiers.

Several parents said that at the time of placement they had recalled their own childhood in foster care. One father said, "I thought back to the time I was placed when I was 8 or 9 years old. I felt funny inside like I was alone again. I felt guilty because when I was a kid I felt bad about going away and my kids had to feel the same way—but they were younger."

Problems and possibilities

These examples from the pretest and exploratory interviews indicate the kinds of problems that will have to be solved in the coding and analytic phases of the study. There will be three critical tests for use of the data: (1) Whether a typology of parents' feeling reactions to child placement can be developed that is conceptually clear and separates clusters of responses from each other; (2) whether these clusters are valid and meaningful in terms of other important study variables such as social attitudes, family pathology, and reason for placement; and, finally, (3) whether these clusters can have predictive value in relation to the child's later return to his home.

In discussing the effects of the separation experience on the child, Mary Ainsworth has reported that the child who has been placed away from home typically goes through successive stages of "protest, despair, and detachment."¹³ Without therapeutic intervention, the result is the detached, hard-to-reach, emotionally blunted child. Although it is too soon to predict the outcome of our study, one might wonder whether the placing parent might not go through similar stages. Will the separated parents, depend-

ing on their circumstances, own history, and expectations for the future, fall into clusters of those who despair, those who protest, and those whose detachment is such that rejection and denial of parental roles cannot be breached? Such findings, if they do occur, might have implications for the kind of service provided parents at the time of placement as well as having predictive value regarding eventual family reunion.

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... And as men must now irrevocably perish or survive together, the task of each family is also the task of all humanity. This is to cherish the living, remember those who have gone before, and prepare for those who are not yet born.

Margaret Mead, in "Family," *The Macmillan Co., New York, 1965.*

FAMILY DAY CARE

for
children
of
migrant
farmworkers

MARION L. SHERIDAN

Two-year-old Willie spent many weeks of his second summer under the neglectful eyes of his senile grandmother while his mother worked in the fields. Willie was often wet and hungry. His mother did not want to leave him but she did not know what else to do. The family needed her wages, and there was no one but the old grandmother to take care of Willie. Each weekday his 5-year-old sister went to a day-care center run by the county for children over 3, but there was no place for Willie to go.

Willie's third summer was different, however. He spent 5 days each week, from 8 a.m. to 5 p.m., in the care of a family day-care mother in her clean and pleasant home. Willie was never hungry; his health improved. He learned to play with other children. He was happy, and so was his mother.

Every summer hundreds of migrant farmworkers like Willie's parents come with their children to work in rural areas of Pennsylvania harvesting fruits and vegetables. The State has supported day-care centers and summer schools for the children of migrant farmworkers since 1955, but until the summer of 1965 it did not offer care for children under 3 years of age. A new service especially adapted to the care of young children is now developing, however, through which they can be cared for in family homes by the day. A pilot project supported by the Office for Children and Youth in the State Department of Public Welfare, the Pennsylvania State University, and the public child welfare agencies of three counties, the service has been carried out for two summers and will be continued in the summer of 1967.

The project was started after reports from social workers, nurses, and ministers working with migrant families pointed out the continuous need of migrant parents for ways of caring for their young children while they worked in the fields or for other reasons. These reports described conditions often physically harmful to children. Sometimes, for instance, small children had to stay all day in a bus parked near the field in which their parents were working and received only occasional attention from their mothers as the crew leaders permitted. Babies might be left unfed for hours. Social workers had tried to arrange for care in the camps for these children, but they found that only the most elderly or most irresponsible women remained in the camps at the peak seasons to care for children or that other children between the ages of 4 and 8 who should have been in the day-care centers were left behind to care for younger brothers and sisters.

These reports, together with statistics gathered from year to year on the number and ages of children coming with migrant farm families each summer to Pennsylvania, convinced the State Office for Children and Youth that it should try to provide care for children under 3 as well as for older children. Consequently, a pilot project in family day care was started in the spring of 1965 and was extended in 1966.

The project has several objectives: to find a way of caring for the young children of migrant farmworkers helpful to them and acceptable to their parents; to determine the problems involved in giving such care; to interest State and local child welfare agencies

in providing such care; and to compare this type of care with the group care provided for the older children.

Three counties in north-central Pennsylvania—Columbia, Luzerne, and Potter—were chosen for the project. About 1,600 migrant farmworkers come to Columbia County each summer; about 500 to Luzerne; and between 500 and 600 to Potter. The farms of Columbia County cover a wide area and the migrant camps are considerably distant from one another. For this reason, services for migrant children such as day-care centers and summer schools are located in Bloomsburg, a community nearly equidistant to all camps. In Luzerne County, such services are located in small villages near the camps. In Potter County, which has one large centrally located cooperative camp for migrants and many small scattered camps, most of the services have been located near the central camp.

Setting up the service

These three counties were chosen for the pilot service project because they had well-established public child welfare agencies and because an increasing number of migrant workers with small children come into the counties to harvest their crops each year. As the State Department of Public Welfare through its child welfare program has supervised these agencies for many years, it was not difficult to work out plans quickly and easily. The department agreed to pay for the entire project and to furnish social workers to the county child welfare agencies, which in Pennsylvania are under the county commissioners, to carry it out. Though directly responsible to the supervisor of special services in the State Office for Children and Youth, the social workers would work closely with the directors of the county child welfare agencies.

Marion L. Sheridan, supervisor of special services in the Pennsylvania State Department of Public Welfare, administers a program of social services, including day-care centers and family day-care homes, for the children of migrant farm workers. A graduate of the University of Pennsylvania School of Social Work, she has long been in the field of child welfare, as a county director, field representative, and consultant. She has also been a member of the Committee of East Coast Officials on Migratory Labor.



The directors of the county agencies gave the social workers the names of persons who might apply for children for foster care and assisted them in setting up a general policy for the acceptance and supervision of day-care homes and establishing a rate of payment to the family day-care mothers exceeding that established for foster care, but which the county agency thought justifiable for the service required. The social workers and county directors together regularly reviewed applications and approved each family before a child was placed.

The project in operation

Most service programs for migrant farmworkers in Pennsylvania last less than 3 months. For this reason, it was difficult to recruit trained child welfare workers for the program, most of whom have or want permanent positions. We, therefore, employed recent college graduates. What they lacked in experience they made up in enthusiasm for social work.

These young workers were assigned to the counties 2 to 3 weeks before the farmworkers were expected to arrive to give them some time to become acquainted with the methods and philosophy of the day-care centers for the children of migrant farmworkers, to visit people in the community to find out their attitude toward the new program, and to begin their orientation to the family day-care program through conferences with the directors of the county child welfare agencies.

Recruiting homes for family day care for the children of migrant farm families is no easy task because there is no way of knowing how many children will need care before the families arrive. To offset this uncertainty, in the early spring of 1965, each public child welfare agency reviewed its applications for foster care of county children and considered which families might be interested in providing family day-care service to the children of migrant workers. By the time the social worker arrived in the county, some families were prepared for her first visit. Having a few applicants approved for study by the agencies encouraged and helped new social workers and eased the job of finding homes. In the spring of 1966, the procedure was repeated. Recruitment began with the family day-care mothers of the year before. All but two reapplied and were accepted.

Each summer when most of the migrant farmworkers had arrived, the family day-care social workers visited the camps with social workers from the day-care centers and together they enrolled the children

or both programs. Much of the groundwork for the new program had been done during the many summers that the day-care centers had been in operation in these counties. Farmers and crew leaders accepted the social workers in the camps. Mothers already familiar with the work of the day-care centers welcomed them. Over the years they had learned to trust the social workers and teachers to provide good care for their children. They now accepted the explanation given them regarding family day-care for small children. After the children were enrolled, the social workers made plans for transporting them to the family day-care homes and to hospitals and clinics, and helped family day-care mothers and the children's own parents understand the problems a young child faces in leaving home daily and in growing up.

There were, however, critical moments each spring as the program began when it seemed that not enough homes would be available. Both years, local newspapers carried short articles about the family day-care project and radio stations in the area made announcements about it. The greatest help, however, came from the churches in the communities. (All services for migrant workers in the area have been achieved with the close cooperation of church and governmental agencies.) The State Council of Churches, an association of Protestant churches, gave wide publicity to this program and local clergymen in the three counties made direct appeals to their congregations for day-care families.

When the project began in 1965, two county agencies expected to provide care for 19 children under 3 years of age for 10 weeks. As it worked out, they provided care for 29 children in 6 family day-care homes. In 1966, although a late harvest season brought fewer workers than usual, the three county agencies placed 66 children in 20 homes.

Daily attendance of the children in their day-care homes both years was high. In 1965, in Columbia County, of the 35 days of care given 27 children, 3 attended all 35 days; 5 attended for 29 days; 13, for 25 days; 3, for 20 days; and only 3, for less than 20 days. Attendance for 1966 was at about the same level. The good attendance record seemed to indicate that parents needed the service.

Quality of care

Most of the couples who applied for these children were young couples who had young children of their own, lived in modern, ranch-style homes or remodeled farmhouses, and had good incomes. We had hoped,



A family day-care mother helps one of the two migrant children in her care get ready for the trip back to the camp.

that with the help of the social workers the families would provide good child care for the migrants' children, but most of the families with whom children were placed exceeded our expectations. In our initial study of their homes, we learned from the kind of care they gave their own children that their knowledge of modern methods of child care and nutrition was good and that they were able to be firm with children without resorting to punishment.

The comforting they gave sick or fearful children was perhaps the best feature of the care they provided. Many migrant children have poor health because of the conditions under which they live. Therefore, many of the children were ill during the time of care. One day-care mother rocked and held a child with an ear infection over and over for days until the condition cleared up. Another, on the advice of a physician and the consent of the mother, kept a child who had a high fever in her home for several days.

The day-care mothers were equally sensitive to the needs of fearful children. One social worker, in telling the supervisor of an experience she had in visiting a day-care home, said that when the day-care mother heard a slight cry from the bedroom in which a 2-year-old child was sleeping, she excused herself, went to the bedroom, and returned with the child in her arms saying, "Joyce Ann is always frightened when she awakens, so I pick her up and rock her for a while."

As time went on each day-care mother expressed more and more concern over the deprivation the children suffered. They helped the parents in various

ways from time to time. For example, on hearing that the parents of the two children for whom she was caring had been hurt in an accident, one day-care mother took them and the older children of the same family into her home and cared for them until their parents were released from the hospital.

The day-care mothers' enjoyment in caring for these children was apparent when 12 of the day-care mothers in the Columbia County program met one evening last summer. In exchanging ideas about child care, they told of the pleasure their work with the day-care program gave them. For example, one mother who had had a major operation followed by a post-operative reaction the spring before said she had not taken a sedative since she had had the children in her care, in fact, had not had time to "take pills." The day-care mothers were full of compassion for and understanding of the migrant mothers. They wanted to know how the mothers kept the children so clean and taught them to be so polite when they work such long hours. Although there was no formal plan for the children's own mothers and the day-care mothers to meet, they did find many natural ways of keeping in touch with each other. The day-care mothers sent notes home; they talked over the telephone with the children's mothers; and a few visited the mothers in the camps. Next year, we hope, migrant parents will be able to visit the family day-care homes.

To be sure, not all homes gave the same high quality of care. One of the first applicants in the 1965 program was a woman who lived in a large farmhouse with a wide porch surrounded by plenty of outdoor play space. At first she was enthusiastic about caring for migrant children. Because she was a farm woman who had brought up a large family, it seemed likely that she would do well as a family day-care mother. However, after the worker's first visit, the woman began to vacillate, to show fear about health problems, and to resent having to have a health examination and a tuberculin test to meet agency requirements. It was obvious that she would be both demanding of and dependent on the social worker. However, because in working with migrant children the agency has to work quickly if the need is to be met and as it appeared that this woman could give good care to children, the social worker decided she could help her with her personal problems. So, within 2 weeks we placed five children with her. Soon the worker found that the woman was leaving the full responsibility for the children to her 16-year-old daughter and her own mother while she went on with

her usual household duties without involving herself with the children in any way except to prepare the noonday meal and to feed them with the family. The children received physical care to be sure, but little mothering or other individual attention. The worker soon moved all the children except one child to other homes.

The problems

Among the problems the project expected to have to solve, the first seemed to be how to place Negro children with white families. Because Negro migrant farmworkers had been coming to these communities for many years and because the applicants for migrant children initiated contact with the child welfare agency, we assumed that each family offering help knew that the children were Negro. The social worker, however, gave each day-care mother an opportunity to discuss any problems she might have relating to the difference in race; but no mother ever pursued the question except in terms of the health of the children to be placed. Once the children were in the homes, a natural relationship developed, as it does with almost any group of children. Almost all day-care mothers were so warm and loving that soon their own children and the day-care children were playing together freely and naturally.

Some resentment arose in some neighborhoods, however. A few adults asked provocative questions of the day-care families and some schoolchildren made malicious remarks to the children of the day-care families. No argument or insult seemed to have much effect on the day-care families, however, probably because they were convinced that what they were doing was right. One day-care mother from an upper middle class suburb told her neighbors that she knew of no better way of preventing her children from acquiring racial prejudice than to have them play and live with children of a different race and culture.

The second most important problem seemed to be that of the general health of the migrant children. During routine examination and immunizations at the county child health agency, we found that some of the children needed additional medical care and that many suffered from the complaints of children who do not receive adequate health services. Eight of 27 children in one program had umbilical hernias; 2 needed remedial surgery. Most of the children had colds and coughs, conditions that particularly plague migrant children, who must adjust to constant

temperature changes, because, even in the fall, migrants live in barrack-like houses.

Transporting the children to and from the family day-care homes was also a major problem for the program. In fact, we found transporting children to be the most costly and difficult part of the program. In the first year, we planned to use the buses that carried older children to and from the day-care centers to bring the young children to the foster family homes. However, the drivers refused to be responsible when they realized very small children were to ride in the care only of older brothers and sisters. We, therefore, used several other methods of transporting the young children back and forth. At first we tried to use commercial drivers by hiring small buses and taxicabs. In one county, when this proved too costly, a few mothers who had applied for children but whose homes were not then in use agreed to transport children to the homes of other families until they themselves had day-care children to care for. One migrant mother who owned a car brought the children from her camp. All noncommercial drivers were required to carry extra insurance, and all drivers had a paid assistant who watched the children. At times, lack of transportation prevented our offering the service in certain camps because the cost of picking up two or three children at a great distance from the homes was prohibitive.

At first, the day-care mothers were overwhelmed at the thought of assuming the care of six children, as we at first asked each to do. Three children seemed to be the most each woman felt she could manage. A few day-care mothers, however, after having cared for three children for a week, decided

that the task was not so difficult as they had expected and agreed to take one or two more. A few mothers even accepted six children.

The social workers gave constant support to the family day-care mothers by visiting the homes almost every day. They helped the mothers understand the children's behavior and find ways of making them happy. They discussed the health of each child and made appointments with physicians and nurses at nearby clinics and hospitals. They purchased diapers, training pants, nursing bottles, and extra clothes for cold days with money collected in fees paid for these necessary articles. Neighbors freely lent play pens, walkers, and cribs, and the day-care centers made cots available to the homes.

Mothers and children

We have found in working with migrant mothers that they seem to reach out at all times for any service that can improve the welfare or education of their children. Some of the migrant mothers readily took the morning or afternoon off from the fields to take their children to child health clinics at the request of the social worker, even though it meant a significant loss of wages. When a mother received a note from the social worker or the day-care mother by way of her child, she usually returned a written reply or discussed the matter with the social worker when she saw her next. During an outbreak of influenza in one camp, the social workers sent notes to migrant mothers describing the best diet for their children and asking them to report any symptoms of the disease. As a result, one mother reported that her child had a rash on her leg. The social worker and the family day-care mother thought the rash serious enough to require a visit to a physician. After examination, he sent the child to the hospital to be treated for a staph infection.

The parents paid the agency from \$1.25 to \$2 a week for the family day care, but any amount they could afford was acceptable. Almost all parents paid something willingly.

Most of the children adjusted well to the family day-care homes. Although the cultural and environmental changes often seemed too great for these little children at first, by the third and fourth day the initial reaction of most of them—whether tearful, moody, silent, or hostile—began to change. They became interested in the family day-care mother and the other children in her care and seemed cheerful and happy most of the time. However, if it appeared

A foster family day-care father greets a baby who has just arrived from the migrant camp. Another migrant baby being provided day care in this home is not shown in the picture.



within a few days after a young child was placed in family day care that he was not ready to be separated from his mother, we helped the mother make some other arrangement such as helping her to see that the child needed her at home or, if she had to work, helping her to find care in the camp or to place an infant in regular foster homes of the agency.

The greatest environmental change for the children was in eating and sleeping habits. These children seemed to sleep more than other children of their age. Although many children sleep to escape change, it was evident that these children slept from exhaustion as well. Camp life is noisy, and the camp settles down later than most communities, especially on a weekend. Most of the children in family day care had to have two long naps a day. Nearly all seemed to be afraid to be left alone to sleep, and they did not outgrow this fear, although they were accustomed to having little or no attention paid them while their mothers were working. One child, upon waking and being picked up by the day-care mother, looked in her face with surprise and asked, "Don't you have to work in the fields?"

After one little girl had slept all day in the family day-care home and could hardly be awakened to eat, the social worker asked the child's mother in the migrant camp whether her child had been sick the night before. The mother replied in surprise that the child had been well enough to run around the camp all night.

The family day-care mothers reported that the children ate well once they became accustomed to a few new dishes. Some of the children were still young enough to be bottle fed; others brought bottles as pacifiers, but once they were given solid food, they gave them up.

Although only observation and judgment have been used to evaluate the service, we believe that the purpose of the family day-care program was in general achieved, particularly in 1966. Migrant mothers accepted the family day-care homes because

they trusted the social workers and were willing to learn from them and the day-care mothers how to improve the care they gave their children. Much improvement was accomplished in the care the migrant mothers gave their children through imitation with no words spoken. For example, if a child went home with a note pinned on his diaper saying "better way," he was likely to be returned the next day with the "better way" faithfully copied.

We were surprised how many family day-care mothers in the communities trusted a new and different program when supported by the county child welfare agency and, as a result, gave intelligent and loving care to children regardless of motivation. Our need to find these homes quickly engaged the interest and assistance of many people in the community. Newspapers, radio stations, and churches not only provided publicity for the program, but also served as avenues to good will.

As for a comparison between the value of family day care and the group care at the centers, we believe that a day-care mother caring for three to six children can meet the physical and psychological needs of young children more immediately and personally than teachers providing group care. This does not minimize the value of the care given at the day-care centers, but it does point up that in family day care the caretaker can identify and concentrate on the special needs of each child. A day-care mother in her own home can be close to the fearful child who needs to know immediately on awakening from a nap that he is not alone, and she can comfort a child during the long day when he suffers from a painful illness. The physical problems of children who have had no medical care can well take most of a day-care mother's day; yet the day-care mother must also alleviate the fears that accompany a new experience. The quick response of these children to the change of environment, methods of care, and improvement in health led us to believe that, for young migrant children, family day care can be a valuable experience.

. . . We owe to every young person in America a fair start in life—and this means that we must attack those deficiencies in education, training, health, and job opportunities by which the fetters of poverty are passed on from parents to children . . .

President Lyndon B. Johnson to the 88th Congress, January 21, 1964.

LEARNING with TEACHERS

ALBERT J. SOLNIT, M.D. ● MARY H. STARK

● Schoolteachers and clinicians from pediatric and psychiatric clinics for children have much to learn from each other about child life and child development. Long convinced of this fact,¹⁻³ the Child Study Center at Yale University has for more than a decade been engaged in a continuous collaboration with two local school systems in Greater New Haven, Conn. This collaboration has underscored the reciprocal value of a close working association between teachers and clinicians. The experience has also impressed the clinicians engaged in it—a child psychiatrist and a psychiatric social worker—with the potentials of the universal education system as a preventive force in society's struggle against an alarming incidence of mental illness.

We began the experiment with an effort to establish conditions in which we could make our clinical understanding of children and their families available to schoolteachers. At the same time, we wanted to tap the enormous reservoir of knowledge and experience schoolteachers had gained about children in their daily experiences. Being aware that teachers and clinicians possess knowledge derived from different levels of observation and inference, we hoped thus to enrich our own work as teachers of medical students, pediatricians, psychiatrists, psychoanalysts, nurses, and psychologists.

Since then we have engaged in a continuous collaboration with schoolteachers in elementary schools in the greater New Haven area—especially in two schools, one in an upper middle class professional community and the other in a poverty-stricken area. Our work with the teachers has focused on children with problems in learning or school adjustment.

Assuming from the beginning that the school's major mission is to provide each child with educational opportunities that are optimal for his development in a democratic society, we have been mindful of the confusion that results if teachers are expected to be diagnosticians and therapists and, conversely, if child psychiatrists, social workers, and psychologists are assumed to be experts in child education. Nevertheless, we have found that each group of experts can learn from the other by making appropriate and selected translations and inferences.

Each year we have met with groups of teachers regularly throughout the school year on a weekly, monthly, or bimonthly basis. In one school the group consisted at first of 8 to 10 teachers of the first, second, and third grades; then of teachers of kindergarten, first, and second grades; and later of teachers of the second, third, and fourth grades, and so on. The school nurse, social worker, and psychologist also attended the meetings. Thus, over a 5-year period, all of the teachers in this school (which covers kindergarten through the sixth grade) participated in the conferences many times. In another school the conferences were limited to six kindergarten, first-, and second-grade teachers. In every instance the

The work reported in this article has the endorsement of the Boards of Education of North Haven and New Haven, Conn., and is supported by the Children's Bureau and the Connecticut State Department of Health.

principal of the school has been present at the meetings. In addition, special teachers such as speech or remedial reading specialists have been included when a child or a problem of concern to them was under discussion.

From the beginning, we have stressed both the scope and limitations of our expertise as a psychiatrist and a psychiatric social worker, pointing out that we were interested in a true interprofessional exchange of knowledge. In this way we have gained acceptance of the project in the school community—a prerequisite for fruitful collaboration with the educators.

The meetings have been intended to serve as a means of exchanging opinion and knowledge for the benefit not only of the child under study but also for other children, since the discussions have usually generalized from the particular child under consideration to others with similar characteristics or problems. Most of them have been organized to focus on a particular child and the teacher's efforts to help him, but the discussion has often broadened to a consideration of questions of general concern such as discipline, curiosity, or socialization in early adolescence. Before each meeting, a short statement about the child and his problems is sent by the principal to the clinical group. Confidential information is protected by measures designed to insure the anonymity of the child.

As the teachers discussed a child, his school experiences, and his background, we attempted through questions and comments to convey some insights gained from our clinical experience and studies in the fields of psychoanalysis, child development, family dynamics, and child psychiatry. The discussions enabled the teachers to translate these insights into working knowledge that could be applied effectively in dealing with the child and with specific learning situations in the classroom. Thus, we did not emphasize psychiatric diagnosis or referral for clinical care. In fact, over a 10-year period only a small proportion of the children we have studied in these group meetings have been referred to community agencies for pediatric or psychiatric evaluation and treatment.

Underachievement

Underachievement in its various aspects was the most frequent school difficulty to come under discussion. The teachers often implicitly or explicitly correctly related this problem to the child's preceding

and continuing experiences at school. Often they also exhibited an awareness of the relation of the child's family background and his parents' attitude toward education to his underachievement.

By comparing the child under discussion with others in his class and by comparing his experiences and performance under a previous teacher with his present performance, the group invited a careful study of the reasons for the underachievement. This led to such questions as: Is underachievement in this child a result of an internalized conflict, a reaction to conditions in his home, an adaptation to the deprived environment, or a reaction to his present teacher or fellow students? In other words, is the difficulty in the child himself or is he reflecting the underachievement of his family, his neighborhood, or his subculture? For example:

Johnny, age 8, had been promoted to the third grade with reservations about his skill in reading and writing, subjects in which he seemed to have very little interest. Johnny and his parents had moved from South Carolina 2 years earlier and were living in a New Haven slum. His parents, according to the teacher, viewed school as a duty a child must accept pleasantly until he is 16, when he is permitted to drop out of school and go to work. They did not regard reading and writing as being as essential for adult work as skills requiring muscular coordination and strength. While they would like to have had Johnny do well in school, academically and socially, their compliant attitude toward the school's expectations did not have as much influence on Johnny as their implicit lack of interest in the goals of schooling. Johnny did not have any notion that schoolwork was an essential investment in his future.

The teacher-clinician group considering Johnny agreed that it would be helpful to Johnny if someone worked with his parents. At the psychiatrist's suggestion, the principal asked them to come to the school, thus demonstrating his interest in Johnny and his parents and in Johnny's schoolwork. He talked to the parents about how they might help Johnny do better work. He established a very good relationship with them and saw them several times. In the ensuing year, Johnny gradually gave evidence of taking his schoolwork more seriously. His changed attitude, as well as that of his parents', was at first manifested in a changed appearance. He seemed more rested, and his clothing and bodily cleanliness were obviously receiving more parental attention. His schoolwork slowly improved, as did his interest in demonstrating his proficiency in learning. His parents became active participants in the PTA and exhibited a possessive pride in the school.

When a child is not achieving at his capacity regardless of the cause the teacher often feels that she is underachieving. A study group discussing such a child can encourage the teacher to balance her self-criticism with a long-range perspective to transform her scrutiny of the situation into a constructive instrument for her own and her pupil's advancement.

Therefore, our questions and comments as clinicians were aimed at bringing out as full a picture as possible of the child's background, his different ways of learning in various situations, and his assets and liabilities. We would often start the discussion with speculative formulations about the child's failure to function up to par in school. The teachers would respond with additional observations and with their own formulations. The dialogue would then proceed until the teachers had devised the beginning of a plan to help the child.

For example:

The case of Phil, a very bright 11-year-old sixth grader, was presented for discussion because he never worked up to capacity. He daydreamed constantly and was very forgetful. Each teacher he had had for the past 3 years had made the same complaints about him. In the discussion group his fourth- and fifth-grade teachers, as well as his current teacher, Mr. A, were present. They reported that Phil was aware of his problem and often said with tears in his eyes that he wanted to do well in school but that he could not concentrate. He did show an interest in science, especially in relation to the human body. He also read a great deal and was in the top reading group in his class.

Asked by the psychiatrist to describe the boy, the teachers said that he was slender, average in height, rather awkward, and not skillful in sports; that he played with one or two rather unpopular children; that his classmates often responded to his forgetfulness and daydreaming by exclaiming, "Oh, Phil! Not again!"

At the request of the psychiatric social worker, the teachers described Phil's family.

Phil's parents were college graduates. They had removed all distractions from Phil's room at home in an effort to help him concentrate on his homework, but he had continued to daydream. He had a very bright sister who was in the fourth grade, a 6-year-old brother with cerebral palsy, who was not able to go to school, and two sisters of preschool age. Phil's father had said that he himself did not "wake up until he was in college."

When the psychiatrist asked if Phil ever requested help from his teachers, Mr. A, his current teacher, reported that Phil was very independent and did not ask for help. His fourth-grade teacher remarked that Phil would "tune out" the teacher and would always seem to be interested in a topic different from the one assigned. Mr. A had spoken to Phil after school about his daydreaming and forgetfulness but this had not helped. He had also had a talk with the boy's parents but this approach had not helped Phil.

The psychiatrist commented on Phil's advanced reading and on the universality of daydreaming, a form of mental scanning that ordinarily facilitates problem-solving mental activity and the acquisition of knowledge. He speculated that in Phil's case the inability to concentrate on what the teacher asked might be a bright boy's way of presenting himself

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as defective. The psychiatrist further suggested that Phil's associations with going to school might be related to his concern about his handicapped, younger brother, who had been born about the time Phil entered kindergarten. He added that perhaps Phil had identified himself with his defective brother as a way of coping with his own feelings about separation from his mother at a time when she was painfully preoccupied with the tragic condition of her newborn son. The teachers discussed this idea as a possibility worth further consideration.

Mr. A suggested that as the first step in an educational plan he and the principal might talk again with the parents to try to find out what might be worrying Phil. The group went along with this, pointing out that Mr. A would then be in a position to decide how to deal with the boy. The group agreed that the teacher should in some way convey to Phil that daydreaming was all right as a companion of but not a replacement for the problem-solving effort involved in schoolwork.

The group did not come to an agreement on whether Mr. A should bring up the subject of the younger brother in talking to Phil. One teacher insisted that Phil's curiosity about the human body offered a logical opportunity for talking with him about his brother's handicap. The rest of the group, including the clinicians, felt that the subject would best be broached by his parents or physician. Phil's teacher, the group agreed, should understand the possible influence of the brother's arrival and condition on Phil but should not accept this as an excuse for Phil to limp along in his work. Some of the teachers pointed out that if more were not demanded of Phil in school, he would regard his distorted impression of himself as correct.

The educational plan devised in the group was modified as a result of an ensuing discussion with the parents, who had responded to the suggestion that Phil might be concerned about his handicapped brother by agreeing to help him attain a better understanding of himself and his family. In accordance with the plan, the teacher insisted tactfully and repetitively that Phil practice and complete his work in a manner suiting his capacities; refrained from criticizing him for daydreaming when he was not reciting or engaged in problem-solving activities; and

conveyed disagreement with Phil's notion of himself as a handicapped boy who could not perform. The teacher did not initiate discussions with Phil either about his brother or about the body in general, but he responded to questions and observations on these subjects if Phil brought them up.

Six months later, Phil's teacher reported that the boy was performing better as a student though he was still occasionally absentminded and socially awkward. The social awkwardness was no longer a major concern, since the parents had reported Phil had a good relationship with them and their other children.

Obstacles to learning are commonly engendered by the child's previous experiences, motivational conflict, poor impulse control, or a neurophysiological deficit that impairs the child's ability to attend to and acquire the mastery of symbolic expression so essential for formal education. We have observed that the effective teacher begins by providing a learning experience that avoids the obstacles to learning and only later takes a more direct approach to these obstacles. For example:

A teacher noted that an 8-year-old boy became frantic when reading out loud. She, therefore, avoided calling on him in class to read but did call on him to recite in other areas in which he showed confidence and pleasure, especially arithmetic. She also had him read to her alone during several recess periods, and after he showed some improvement she began again to call on him to read aloud in the class. This pupil gradually mastered the difficulty. The teacher did not know for certain what the origin of the difficulty was but suspected that it was related to an unfortunate experience the child had had with a speech difficulty earlier in life.

Some teachers intuitively devise a way of avoiding the obstacles to learning by following clues presented by the characteristics of the teacher-pupil relationship. One teacher placed a hyperactive 9-year-old boy next to her desk because she noted he could pay attention to arithmetic and its abstract symbols only when he was close enough to feel her controlling physical presence and interest in him. In another instance, a teacher placed a 12-year-old girl in the back of the class when she noticed that the girl had to show off if she felt "too close" to the teacher. Initially, she could learn more effectively when the relationship to the teacher was not intense.

Inservice training

From these experiences in collaborative assessment of underachieving children, we have become aware of the value for teachers of a planned collaboration with seasoned educators, child psychiatrists, and

social workers as a form of inservice training or as an internship for new teachers. Younger teachers found the sessions particularly valuable, but older, more experienced teachers also gave evidence of gaining from their participation in the groups.

We learned that the first 2 or 3 years of full-time teaching are crucial in the professional development of young, inexperienced teachers. In a classroom, the full professional responsibility of helping 20 to 35 children learn basic tools of communication and the beginnings of conceptual thinking presents a challenge that is often overwhelming if the teacher does not have appropriate supervision and opportunities for inservice training. We have seen a bright, witty, young person who was given no supervisory help in mastering difficult work problems turn into a frustrated, sarcastic, yelling teacher. With supervision and conferences, the challenges a new teacher faces can be stimulating rather than overwhelming and they can result in professional growth rather than constriction. For example:

Mr. B, who had begun teaching fifth graders only a year before our conferences began, at first constantly tried to put children into the theoretical classifications he had learned about as an undergraduate. Toward the end of his first year with us, however, he remarked that the children did not fit easily into an extrovert-introvert classification system and that such a system was not very illuminating anyway. In the second year, with the support of his principal, he began to present some of the children in his class to the group: an 11-year-old girl whose shyness eluded his understanding; and a boy who in challenging his authority was provoking him to prove that he could be tough and was the boss. Through the openness of the discussion of these children, which continued from time to time throughout the year, Mr. B came to understand that the girl's shyness stemmed from anxiety about her sexual precocity and that the boy's provocative behavior was a poor form of sublimation and the displacement of sibling rivalry. Through his greater understanding of these children Mr. B was able to help them in class. He has often said that the conferences, which he attended for 3 years, have helped him build greater teaching skill on the foundations of his formal training.

In one school where the clinicians organized collaborative discussion groups, the principal ran the school like a "tight ship," partly in response to the threatening unrest in the surrounding underprivileged and disorganized neighborhood. However, he knew his children's families and their neighborhood well and made this knowledge available to the teachers in times of crisis. In the first conference at this school, a young kindergarten teacher described a child about whom she was concerned, and in doing so made it clear that she was being aided by an experienced, older teacher with whom she shared teaching respon-

sibilities. As the conferences proceeded, the clinicians' questions and comments stimulated the principal to transmit his knowledge of the families and home life to his teachers as a matter of course rather than only in crises. This enabled the clinicians to show how the characteristic learning and behavior patterns of the child under discussion were related to the dynamics of his family life as well as to difficulties specific to his developmental stage in the context of the cultural background. These phase-specific difficulties included anxiety arising from the child's separation from his parents or from the necessity to control impulses in the classroom. Thus, the assistance provided to the young teacher by her senior colleagues and by the principal became elaborated and explicit as we all extended our understanding about underprivileged children.

Pupil-teacher relationship

Thus we demonstrated that clinical theory mainly derived from psychoanalysis can be translated and applied as part of sound pedagogy when it is part of an inservice training program in which the questions, discussions, and solutions are related to everyday teaching problems and to principles of education.

One theory that seemed to be especially helpful to the teachers we worked with was the psychoanalytic concept of identification. This was presented as a complex psychological process through which attitudes and motives are conveyed from one person to another as a result of their relationship. We discussed those factors that promote and those that impede the adoption by the pupil of the teacher's attitudes toward knowledge, recitation, reading, and working alone or in groups.

Throughout the discussions, the clinicians attempted to show how the child's capacity to work at school can be activated through his relationship with his teacher, which, as Anna Freud has pointed out, is not a replica of "the child's emotional tie to either parent but something *sui generis*, a later, more complex, and more neutralized relationship to a group-leader figure."⁴

During this effort we observed that each teacher had a unique mode of describing and relating to her pupils. We also noted that each teacher had intuitively formed a fragmentary but influential relationship within 2 weeks after the school term had started with each of the pupils with whom she eventually became effective. When we called this to the attention of our educator colleagues in the groups as a phe-

nomenon worth studying, they corrected us by pointing out that in most instances the period of "latching on" occurred during the first week of school. Some teachers said that if they did not have the beginnings of a relationship with a child before the first week had passed, they expected prolonged difficulties in teaching that child. The teachers gave many examples to show that their particular ways of reaching or influencing a child and a class of children required them to be able to identify in part with the children without regressing to poorly organized behavior and without losing their leadership of the class. Obviously, the full development of these alliances takes place throughout the school year. For example:

Mrs. C, an experienced teacher, reported that she had succeeded in reaching and influencing 7-year-old Jessie, who had begun school with a pattern of tardiness, by insisting that the child come to school on time. Mrs. C said that her insistence had conveyed to this underprivileged child that the teacher regarded her as worth troubling about. In the discussion it became clear that Mrs. C's "benevolent nagging" suited her style of making contact and represented the beginning of a positive relationship with the child and her parents through which they would come to identify with the school's goals for Jessie's education. When Mrs. C was asked at what point she thought she had begun to reach Jessie, she said that it was perhaps a few days after the opening of school when, feeling "nagged" by Jessie's tardiness and tired appearance, she had briefly suggested to the child that she get more sleep and come to school on time so that she could enjoy her schoolwork and do it better.

Thus, we learned that the teacher, even with a class of more than 25 pupils, intuitively at first and more consciously later, makes a unique arrangement with each pupil in her class as well as with the class as a group. This arrangement consists of a partial alliance between the teacher and pupil in which they implicitly agree to work together in a mutually satisfying way, each for different reasons and with different aims. For each party involved this alliance results in a degree of what psychoanalysts call "partial identification"—the child tending to adopt the attitudes and expectations of the teacher and the teacher recognizing the individuality of the child, through sensitivity to his special attitudes. Although this mutual, partial identification includes the friendly desire to please each other, it is not too intense and avoids the conflicts that are characteristic and even desirable in family relationships. It demands a degree of patience from each party and an ability on the part of the teacher to tolerate failure, anger, and disappointment while searching for a successful mode of working with the child, whether

through physical closeness or distance, verbal or non-verbal communication, special projects, or innovations suggested by teacher or pupil.

We have already mentioned the devices teachers improvise for initially avoiding obstacles to learning rather than meeting them head on. Such educational adaptations succeed when the teacher-pupil relationship has achieved the kind of beginning alliance in which partial identification can develop. The devices themselves, however, are derived from pedagogical principles that transcend cultural differences and modes of behavior. They exploit the various alternate senses available to the child for perceiving, organizing, and expressing mental impressions and rely on practice rather than drill. Drill imposes the adult's motives upon the child; but practice actively engages the child's positive motivation, a derivative of his identification with the teacher during the frustrating, often irritating, repetition of the work necessary for achieving mastery and independence.

Other aspects of clinical theory developed in our inservice training sessions included:

1. The relationship and differences between play as a method of learning for the younger child and the work of learning in the older child. (For example, play can be interrupted when it is no longer gratifying, but studying and working at school usually must be sustained through periods of discomfort and frustration before the desired pleasurable mastery of knowledge and understanding of symbolic processes are achieved.)

2. The necessary role of aggression in learning and the way the child's conflicting feelings about aggression bring about problems in learning.

3. The function of self-esteem in promoting or impeding the motivation to work at school or the capacity to adapt socially to the school community.

4. Awareness of phase-specific developmental characteristics as essential for gauging the pressure of frustration, the degree of anxiety tolerance, the function of daydreaming, and the significance of adolescent reactions in a particular child.

5. The role of cultural and developmental determinants in facilitating or blocking a fruitful alliance between pupils and teachers.

6. The assessment of the effects on the child's

learning and behavior of a temporary or permanent physical handicap as a challenge for innovating educational experiences.

In conclusion

We believe that our experience over the past 10 years in collaborating with educators in group discussions has provided an effective exchange of knowledge about children and their families.

Some of the most important results of this exchange are:

1. An enrichment and refinement of knowledge among the educators and clinicians alike about what promotes and what interferes with a child's capacity to learn and develop in school.

2. A greater clarification of the distinctions in functions, methods, and content between the fields of pedagogy and of psychiatric clinical services for children; and a greater awareness of where they overlap in knowledge of and concern for children and their families.

3. A heightened awareness of the advantages of viewing the first years of a teacher's work as an internship requiring supervision and conferences for the continuing development of competence, creativity, and work satisfaction.

4. A clearer understanding of some of the psychological factors that determine the formation of alliances between teachers and their pupils.

On the basis of these experiences we are planning a more systematic and comprehensive collaboration with educators for assuring the availability to teachers of those elements of clinical knowledge that can serve the primary aims of education.

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A FAMILY PEDIATRIC CLINIC

at a community hospital

MILTON MARKOWITZ, M.D. ● LEON GORDIS, M.D.

● In recent years, increased medical attention has focused not only on new diagnostic and therapeutic techniques, but also on the means of increasing the availability of these advances to the patient. It has become increasingly clear that progress in techniques has not been matched by comparable progress in dispensing these benefits to the American public. Nowhere, perhaps, is the gap between medical knowledge and its general application more apparent than in the care of the medically indigent, ambulatory patient. While communities have usually provided in some way for hospital care for the indigent, support for the medical care of ambulatory patients has been meager. But even where the financial barriers to care have been lessened through Federal or State aid, patients are still confronted with a major obstacle to good care—fragmentation of services.

This fragmentation is the result of a variety of factors. Modern subspecialization within specialties such as pediatrics has resulted in the proliferation of clinics, so that to receive complete care the patient must often be seen by many different medical specialists, frequently on different days of the week. Furthermore, in clinics attached to teaching hospitals, the system of rotating house staff results in lack of continuity in patient care. In this system, there is

generally no single physician who is responsible for the total care of the patient and therefore little coordination among the physicians caring for parts of the patient's problem.

Such fragmentation of care is most pronounced—and most detrimental—in the care of the chronically ill. It can be especially detrimental in the care of a chronically ill child. The impact of chronic illness is often more serious on a young patient than on an adult, since in a child the illness coincides with important developmental changes. Moreover, responsibility for a child's long-term care rests not with him, but with his parents who are often burdened with the care of other children and so have difficulty in taking the child to several different clinics. In addition, when chronic illness occurs, particularly among the indigent, a cyclical process is initiated: The impact of long-term illness in the family often exacerbates many existing psychosocial problems that in turn interfere with the ability of parents to care adequately for their chronically ill child.

In an effort to attack some of these problems and to improve and coordinate the medical care of chronically ill children, the Sinai Hospital, a voluntary hospital in Baltimore, established a Family Pediatric Clinic in 1963. Initiated with a grant from the Thomas Wilson Foundation and now supported by

the Children's Bureau, the clinic's primary objective is to provide family-centered pediatric care to families with a chronically ill child. Recognizing the importance of the family as the basic social unit in providing medical care, the clinic offers total health care for all the children in the family as well as for the chronically ill child.

Since Sinai Hospital is a teaching hospital, another major objective of the clinic is to provide pediatricians in training with the kinds of experiences they are most likely to encounter in their future pediatric practice.

In recent years, there has been increasing concern over the inconsistency between the training that pediatricians receive during their hospital residency and the problems they subsequently encounter in caring for children in the community. The chief reason for this inconsistency is that today pediatricians in this country are being trained almost entirely at large university centers. Because these institutions attract many patients who have complex medical problems, the young physician's learning experience often is based primarily on unusual and esoteric cases and on relatively few of the more common conditions seen in practice. Such experience with complex medical problems is, of course, invaluable for understanding disturbed physiology. It sharpens the young physician's powers of observation, and develops an inquiring mind. However, as Dr. John Paul of Yale University said 15 years ago, "Sick people at hospitals are isolated specimens . . . segregated from their environment, removed from the circumstances from which they became ill, and separated from their families." Wrote Dr. Paul:

All of [this] is done to create a proper atmosphere of diagnostic study and careful management on the physician's part, free of outside distractions. It may be trite to point out that these outside distractions are the very thing which the modern doctor needs to study, also. In order for us to handle patients accurately, it is necessary to bring clinical judgment to bear not only on the patient, but also on the circumstances under which his illness arose.¹

Dr. Paul's comments have at least as much relevance today as when they were written. Moreover, the more scientific and the more automated the hospital centers become, the less emphasis is likely to be placed on teaching doctors the broad aspects of medical practice.

As a hospital resident, the pediatrician is naturally involved with the immediate illness. His contacts with the patient's family are brief. He rarely obtains an adequate family history and, therefore, has only a

limited awareness of the family milieu and the social conditions to which the patient returns following discharge.

However, most pediatric patients never need admission to the hospital as inpatients. It is now generally acknowledged by medical educators that the pediatrician's training in care of the sick in the hospital must be supplemented by experience with ambulatory patients. But simply allocating more of the resident physician's time to a crowded, uncomfortable clinic or emergency room does not solve the problem because, unfortunately, the scope of training in many outpatient departments is still very narrow. Much of the teaching is carried out in a specialty clinic environment by pediatric subspecialists who, although experts in their particular fields, do not have the time for, or the interest in, the broader aspects of child and family care. Moreover, the system of scheduling the clinic physicians make it difficult for them to gain any long-term experience in guiding the physical and emotional development of children, in counseling in social and psychological problems, and in the use of community resources.

In recognition of these deficiencies, the American Board of Pediatrics has recommended an additional year of training for pediatricians, after the 2-year hospital residency, to be focused on problems of behavior, of school and family life, and of chronic and handicapping illness—training to be gained "in contact with other community health resources."²

With these considerations in mind, the Family Pediatric Clinic at Sinai Hospital has been organized to serve as an active training and teaching instrument for pediatricians in training, integrated with the total training opportunities provided by a community hospital for physicians as well as paramedical staff.

How the clinic operates

Families are admitted to the Family Pediatric Clinic if they meet the following qualifications: (1) the presence of a chronically ill child in the family; (2) evidence of medical indigency; and (3) residence in the census tracts that Sinai Hospital serves.

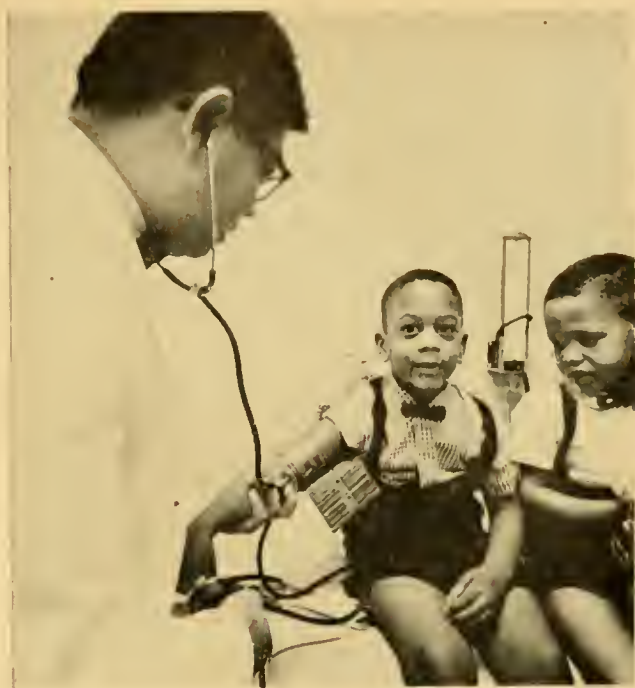
The clinic is directed by the hospital's assistant pediatrician-in-chief and is staffed by a pediatrician in training (family pediatric fellow), two part-time staff pediatricians, a public health nurse, a social worker, a clinical psychologist, and a speech therapist. Psychiatric services are available, when needed, from a part-time psychiatrist on the Family Pediatric Clinic staff.

The clinic differs in several respects from traditional hospital outpatient services. In the first place, it does not focus on any one chronic disease, organ, or particular condition. Chronic disease is not viewed primarily as a matter of classification, descriptive physical findings, or an array of laboratory tests, but rather as a handicapping condition that demands a careful assessment of the social, educational, and emotional impact on the child and his family. Moreover, the Family Pediatric Clinic is concerned not only with treatment of the illness, but also with the maintenance of health in the broadest possible terms. Its care begins with a health appraisal of *all* the children in the family by the resident physician, public health nurse, and social worker. Much of this care consists of preventive services. However, when acute illness does occur, care of the patient involves an appreciation of the effect of the illness on family function, rather than a limited disease-oriented approach.

An effort is made to select those cases in which a multidisciplinary approach to health care would appear to be most beneficial. These include families in which social problems seem likely to prevent successful medical management as well as families in which the chronic illness seems to be an intolerable burden added to already overwhelming social problems. Thus, prior to accepting a referred family into the program, the clinic staff surveys the medical, social, and emotional aspects of its problems by reviewing material from the referring clinic or social agency, by personal interviews, and by discussions in staff conferences.

In those families accepted for care, all medical care for the children, both in the clinic and at home, is provided by the family pediatric fellow. Regular clinic sessions meet four times weekly for scheduled appointments. In addition, the clinic is open for walk-in visits throughout the week. Night and weekend service is provided on a 24-hour basis by telephone and, when needed, by home visits. At least one scheduled home visit is made to each new family by the fellow, who makes subsequent visits, when needed, in times of acute illness.

Each clinic session is conducted by the family pediatric fellow and the public health nurse. The public health nurse makes a health survey of each new family through clinic interviews and a home visit. The parents in each family are seen by the social worker initially and as indicated thereafter. In the initial interview, the social worker, in talking with the parents for the purpose of social evaluation, describes



The family pediatric fellow at the Sinai Hospital takes the blood pressure of a young patient whose brother looks on.

the functions of the clinic to each new family and provides them with an instruction pamphlet for the patients, prepared by the staff.

In providing complete medical care for all the children in each family, the family pediatric fellow becomes in essence the family pediatrician. Consultants in other specialties are called upon when needed. When this is done, the fellow is either present during the specialist's visit or in close communication with the consultant so that the specialist's recommendations can be integrated into a total health program for the family on a continuous basis.

Through his visits to the home, the fellow gains a firsthand impression of the environment. He develops a greater understanding of intrafamily behavior, learns to identify the areas of strength in each family, and becomes better able to counsel them in times of stress. In the day-to-day operations of the Family Pediatric Clinic, he works closely with the other members of the clinic's staff.

Through frequent discussions of specific problems, team members continuously reappraise their work with each family and coordinate their efforts. Thus, when family crises arise, as they frequently do in a clinic population, the physician is in a position to more effectively bring to bear the special skills of

the various staff members on a particular problem. For example:

The S family was admitted to the Family Pediatric Clinic because of a 5-year-old child with heart disease. During the long-term management of this family, a crisis developed when an older brother was taken to court because of truancy. Evaluation by the social worker and the psychologist revealed that this older boy's problem was one of school phobia that was being aggravated by disturbed interpersonal relationships in the family. This realization enabled the family pediatric fellow and other staff members to work constructively with the family and the school in trying to manage this child's problem.

Since the clinic places primary emphasis on the structure and function of families, the social worker plays a vital role in the clinic's work. In most of the clinic's families, health and social problems are closely entwined. Since the families come regularly to the clinic, the social worker has a satisfying opportunity to do casework over a period of many months and even years. She is able to evolve a deeper understanding of individual and family problems and thus determine whether patient and family can best be served by concrete casework assistance or by counseling. The social worker coordinates the efforts of other staff members in working with families and helps the members of the team to see the social implications of the medical problems that come to their attention. For example:

The M family came to the clinic's attention because of a young child who had been unsuccessfully treated for severe eczema in several hospitals. The intake interview by the social worker of the Family Pediatric Clinic revealed that the father had chronic alcoholism that had led to serious marital discord. The social worker's support of the mother in dealing with her husband's problem helped stabilize the home. This stabilization was accompanied by major improvement in the child's eczema that was not effected previously by medical therapy alone.

The public health nurse attached to the clinic provides both well-child and sick-care nursing during clinic sessions. She also sees each family at home initially and at regular intervals for followup as indicated. She helps to introduce many of the Family Pediatric Clinic's services to the patients and increases the effectiveness of the staff's recommendations by interpreting them to the families. She not only plays an important role in patient care by bridging the gap between hospital and home, but she also keeps the hospital's regular staff members and student nurses to increase their understanding of the effects of family and environmental factors on child development.

We have often found that apparently healthy brothers and sisters of the chronically ill child have medical and other kinds of problems, particularly in the areas of behavior and learning difficulties. These children, therefore, seem to represent a high-risk population to which more intensive medical services should be directed in all pediatric clinics that deal with chronically ill children. One example among many is the D family, which was referred to the Family Pediatric Clinic because of a child with pica and frequent respiratory infections. In examining the other children in the family the clinic found that an apparently healthy brother had primary tuberculosis and severe school problems as well.

The clinical psychologist has played a vital role in the program. Because of the frequency of behavioral and learning problems found in these families, many of our children require psychologic evaluation. The psychologist also counsels the parents about child-rearing practices that contribute to learning difficulties and also works with staff members from the schools in the area. In addition, he provides consultation to the family pediatric fellow, the public health nurse, and the social worker, all of whom also counsel parents in relation to child-rearing practices.

Regular staff conferences are held three times a week. They are designed to accomplish several objectives: (1) to consider and make decisions on prospective admissions; (2) to stimulate staff discussion in the direction of a unified family treatment plan; (3) to review periodically the impact and effectiveness of our service; and (4) to provide a forum for teaching. Teaching conferences are held for hospital and community personnel during which the health problems of one family are presented in great detail. These teaching conferences are in essence medical-social grand rounds for the hospital. They are attended by 30 to 40 people, including hospital staff

Milton Markowitz, left, is director and Leon Gordis is associate director of the pediatric clinic they describe in this article. Both are also with The Johns Hopkins University School of Medicine, where Dr. Markowitz is associate professor of pediatrics and director of children's rheumatic clinics and Dr. Gordis is an instructor in pediatrics.



and student nurses, house officers, social workers, and community visitors. To demonstrate the value of using community resources in meeting the needs of children, key personnel from community agencies are often invited as discussants.

Experience to date

Thus far, the Family Pediatric Clinic has admitted over 80 families with a total of 250 children. Many of the families have been referred from the hospital's inpatient service, its regular pediatric clinic, or its pediatric specialty clinics. Patients have also been referred from the hospital's recently established genetics counseling unit as well as from outside the hospital—from schools, the courts, and the Division of Protective Services of the State Department of Public Welfare. In 1965, there were over 1,000 visits made to or by the family pediatric fellow, 893 in the outpatient department and 125 at patients' homes. This physician also participated in numerous telephone consultations.

Many of the families served by the Family Pediatric Clinic have undergone significant environmental changes since their admission to the program. Through the efforts of the clinic's social worker, some parents have secured job retraining and employment so that they have either already moved off the public assistance rolls or shown potential for doing so. Some have been helped to secure improved housing which has had a pronounced beneficial effect on the health of the chronically ill child, as well as on all the children in the family.

In addition to the benefits it provides directly to its patients, the Family Pediatric Clinic has provided a valuable educational experience in family-oriented care for its staff, especially for the pediatrician in training. The fellow has the opportunity to follow a number of families continuously during the 12-month period of his training in the clinic. Thus, he can not only watch the growth and behavioral patterns of children and the course of chronic illness, but also sense the development of his own relationship with these families. Because there is often a need to involve other agencies, he comes in close contact with other community resources, such as schools, the voluntary family service agency, and the local department of welfare. Though many of these resources are already well known to the social worker and public health nurse, for the physician it is an educational experience not usually otherwise obtained during his training years.

In addition to its educational effect on its own staff, the Family Pediatric Clinic has had a noticeable effect on the regular hospital staff not directly involved in its program, especially in the hospital's departments of pediatrics and psychiatry. Since the clinic's establishment, many of the hospital's clinicians and nurses have exhibited a new awareness of the social implications of disease. The clinic's weekly teaching conferences are well attended by the physicians, nurses, and social workers of the hospital's other clinics as well as by student nurses. An increasing number of referrals to the clinic are coming from staff members in other departments of the hospital.

While at the present time the Family Pediatric Clinic chiefly involves staff members from the hospital's departments of pediatrics and psychiatry, it is hoped that other departments in the hospital will participate in it as time goes on.

One of the great advantages of the program of the Family Pediatric Clinic is the fact that it is housed and operated in the regular outpatient department of the hospital. In this way, members of the medical and paramedical staff not directly associated with the program learn to consider it an integral part of the hospital's outpatient services rather than an extraneous project. Thus, the clinic's program has had

Case conference at the Family Pediatric Clinic. Left to right: family pediatric fellow, public health nurse, social worker, psychologist, and the associate director of the clinic.



a much more profound and extensive influence on members of the hospital staff than it could have had had it been separated in its own physical unit.

Problems and the future

One of the main operational problems confronting the Family Pediatric Clinic has been the provision of medical care to the parents of the children served. Since Children's Bureau funds are restricted to maternal and child care, it has been difficult for the clinic to provide the services of specialists in adult medicine, not only for the general preventive medical services needed by some parents, but also to care for their episodic illnesses. Such services have been made available by referring the patients to other hospital clinics, at Sinai Hospital or elsewhere, but the ideal of total comprehensive family medical care has not been realized.

Another major problem is presented by difficulties in interagency communication. Families with a chronically ill child often appeal to various community agencies for help with their complex social problems. In many communities, services are compartmentalized and, therefore, do not deal with the total family as an integrated unit. Since each agency sees only its part of the family problem and since communication between agencies is often inadequate, a family not infrequently receives conflicting, and at times diametrically opposite, advice from different sources. As a consequence, the parents of chronically ill children often become suspicious or completely alienated toward all health and welfare agencies.

During the past year, the Family Pediatric Clinic established close working relationships with several public schools in the hospital district. As a result, the family pediatric fellow, the psychologist, the social worker, and the nurse visit these schools frequently and confer with principals, teachers, and guidance counselors on specific cases as well as on general problems which are of mutual concern. Efforts to work closely with local community resources will be expanded this year. Nevertheless, there is need for considerable improvement in the clinic's communications with other agencies. For example, because caseworkers of the State Department of Public Welfare are burdened by enormous caseloads which preclude their going deeply into the many problems of the families they serve, they do not always collaborate with the clinic fully on all aspects

of a family's problem. We have found, however, that having our weekly teaching conferences open to the staff of other community agencies has helped improve our working relationship with many staff members of the city welfare department and other community agencies in addition to stimulating referrals from them.

A question might be raised in regard to the feasibility of applying the Family Pediatric Clinic approach on a community-wide basis. We have been able to work intensively with our families because of the relatively small load of patients admitted to the clinic. Efforts to extend this type of care to the community at large inevitably must be restricted by both financial considerations and severe shortages of skilled professional personnel. Nevertheless, many of the principles involved in the Family Pediatric Clinic can be applied on a larger scale.

In fact, these principles *are* being applied in the new centers for the comprehensive health care of preschool and school-age children that are now being established in low-income areas of Baltimore by the Baltimore City Health Department and four teaching hospitals, with support from the Children's Bureau under a 1965 amendment to the Social Security Act.³ Sinai is one of these participating hospitals, and two pediatricians who have been fellows in its Family Pediatric Clinic are now working in the comprehensive pediatric center which it administers under this program. Their experience in the Family Pediatric Clinic will be of great value in making this new project effective.

Our experience at Sinai's Family Pediatric Clinic demonstrates that total health care of the child extends into many areas outside the medical field, especially into the fields of public welfare and education. We believe that for such care to be optimal, the health provisions of all services should be coordinated under medical leadership. Moving beyond the hospital walls into a vital interest in all aspects of a child's life should not be considered a new departure for pediatricians, but rather an integral part of their commitment to child health care in its broadest sense.

¹ Paul, J. R.: Preventive medicine at Yale University School of Medicine, 1940-49. *Yale Journal of Biology and Medicine*, January 1950.

² American Board of Pediatrics: Changes in training requirements for board examination. *Pediatrics*, May 1966.

³ Social Security Act, Title V, Sec. 532.

a measuring rod for

JUVENILE AND FAMILY COURTS

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● Notable are the publications that, after 12 years in circulation, are deemed worthy of revision, rather than replacement. "Standards for Juvenile and Family Courts" * is in receipt of just such a prestigious distinction. It is an updated and slightly altered version of the 1954 "Standards for Specialized Courts Dealing with Children,"¹ and anyone acquainted with this earlier work can see why a thorough review by many experts resulted in a revision instead of a totally fresh effort.

The Children's Bureau has always had an active interest in the study of juvenile courts and the promotion of the best modern practices in these courts. Its concern has broadened over the years to include family courts. The title of the new "Standards" reflects not only inclusion of principles applicable to courts with a family-oriented jurisdiction, but also a bias in favor of their establishment. The document retains, however, an emphasis on the more ubiquitous juvenile court.

Perhaps it is important to specify what the new publication is not. It does not provide detailed exposition of the many vexing issues both juvenile and family courts confront. It does not propose particular legislative language—a

task already undertaken by the National Council on Crime and Delinquency with the result that six editions of a Standard Juvenile Court Act were produced between 1925 and 1959. Nor does the "Standards for Juvenile and Family Courts" offer a summary of the laws and practices of the many juvenile courts, full and part time, in the United States.

The purpose of the publication is to expound the principles of juvenile and family courts and to set forth the procedures and practices endorsed by a group of experts as reasonable goals for all courts. Thus, it draws from what is best in the courts today and presents guidelines for tomorrow. In doing so, the publication aims at a diversified audience, not only judges and others in regular contact with the courts, but also "all persons interested in improving the juvenile and family courts of their communities." Therefore, it seeks to state the most important propositions for a wide readership rather than to go into detail and extended speculation.

The 1954 document was a groundbreaking statement in support of a modified due-process model of juvenile courts. It appeared at a time when a revival of concern for juvenile court operations was just under way, for in 1954—as compared with today—the number of knowledgeable critics and scholars studying this institution was small. Widespread critical interest had not yet developed.

By contrast, a bibliographical survey produced today would contain hundreds of items representing a diversity of professional perspectives and ranging from the various products of scholarship to documents hammered out in the heat of controversy. The past decade has been crammed with juvenile court ma-

terials, bespeaking a wave of interest in the various aspects of this institution unparalleled since the days of its founding. "Standards for Specialized Courts Dealing with Children" was a forerunner.

Today's "Standards for Juvenile and Family Courts" appears at a time when consensus has developed regarding most of the basic principles espoused in the earlier document. It appears, furthermore, at a time when the drama of the juvenile court movement has shifted from seminars and conference rooms to legislative halls and judicial chambers, including the Supreme Court of the United States. Thus, it should be reviewed for the basic soundness of the principles and recommended practices retained from the 1954 publication and of the modification or expansion of aspects that have, over the past 12 years, assumed significance.

I regard the principles in the 1954 "Standards" as largely sound. The new publication retains the basic ones—some in strengthened form. The significance of both versions is their clear endorsement of the practice of operating these specialized courts—whether juvenile or family—in conformity with the requirements of the rule of law. This calls for emphasis on the judicial character of the institution, but it does not preclude the use of qualified nonlegal professional practitioners whenever legal considerations are subordinate to social considerations.

Due process of law

As those familiar with either version of the "Standards" must realize, the implications of this commitment to due process of law are numerous and com-

*Sheridan, William H.: Standards for Juvenile and Family Courts. (Prepared in cooperation with the National Council on Crime and Delinquency and the National Council of Juvenile Court Judges.) Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 437. 1966. 130 pp. 45 cents. (For sale by the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402.)

plex. Police handling of juveniles, the function of family or juvenile court intake, the conduct of court hearings, the place of the specialized court within a large judicial structure—these and many other issues must be resolved in harmony with stated principles of individualized justice.

With informality a slogan of many juvenile court judges and their staffs, court hearings have in some jurisdictions more closely resembled case conferences than judicial trials. By 1954, it was beginning to be recognized that the price of informality was abandonment of certain values of traditional courtroom procedure. Critics cited the thoughtless departure from rules of evidence, the illogic of proving a juvenile's need for State supervision prior to, or even in lieu of, proof of jurisdictional requirements or the facts of an alleged act. They also cited the debasement of intentionally nonpublic hearings into summary private hearings at which the participation of persons with legitimate interests in a case—a counsel, a social agency representative, a school-teacher—depended wholly on the sufficiency of the judge.

In short, the proper protest against having the criminal court handle juvenile offenders, which had laid the groundwork in 1899 for rapid adoption of a specialized court for children, had resulted in sacrifice of the values of due process to a so-called casework or therapeutic intervention model. Many proponents of the virtues of juvenile justice had chosen to ignore the reality of authoritative imposition of rules, regulations, and even punishment and the stigmatizing effect of adjudication as a "delinquent."

Character of hearing

In 1954, "Standards for Specialized Courts Dealing with Children" issued an unmistakable policy pronouncement on the character of the court hearing. There should be "two separate parts which may or may not be continuous . . .":

1. The hearing of the evidence necessary to make a determination as to the court's jurisdiction and the facts alleged in the petition.

2. The hearing (if the court should find the child subject to its jurisdiction) of social evidence, including recommen-

dations of the probation officer, culminating in disposition of the case.

The informality of the hearing, according to this policy, should not "mean that the court ignores rules of evidence or fails to establish procedures for its actions." The child's parent, other guardian of the person, or guardian *ad litem* should attend the hearing. Only after the facts alleged in the petition have been established should the court move to the second part of the hearing relating to disposition.

By these recommendations in 1954, the Children's Bureau squarely endorsed the principle of bifurcated hearings and certain essentials of due process—representation of the child's interest by some related or specially appointed adult, the right of parent or child to introduce witnesses and rebut evidence, and emphasis on the spirit (if not the legal letter) of procedural regularity. In doing so, the Bureau took a "harder" stand in favor of formality than was evident at the time in many courts, in the language of most juvenile court acts, or in the writings of other standard-setting organizations.

In the 1966 "Standards" a greater spelling-out of procedural details is apparent. This is hardly surprising: Consensus on the character of hearings (especially in contested cases) has grown in the 12-year interim and the experience with more formal procedure in specialized courts has produced questions, and demanded answers, on aspects of court operation previously seldom recognized. Evidentiary standards for court proceedings are now more fully stated; hearsay is inadmissible in the first part of the hearing and a requirement of "clear and convincing proof" of delinquency is imposed.

One earlier position is reversed. In 1954, the "Standards" stated: "No person in the court should assume the role of prosecutor." Now we are told:

No *staff member of the court* should assume the role of prosecutor. This follows from the noncriminal nature of neglect and delinquency proceedings. However, an attorney to represent the State, especially in contested cases, should be available to the court. This is necessary in order to prevent the judge from being placed in the untenable position of being a party to the proceedings. (Italics supplied.)

But, notwithstanding this procedural emphasis, the draftsman and consultants on the 1966 version justifiably retain their faith that the virtues of informality can co-exist with the requirements of order and dignity.

. . . It should not be forgotten that the real nature of the hearing will depend to a great degree on the ability of the judge and other court officials to convey the court's interest in the child and his family and to avoid expressions of disgust, blame, or anger, or indifference.

And, I would add, unless we find a way to cope with the volume of cases, the effort is doomed. Average hearing times of 7 to 10 minutes per case allow no room for "individualized justice"!

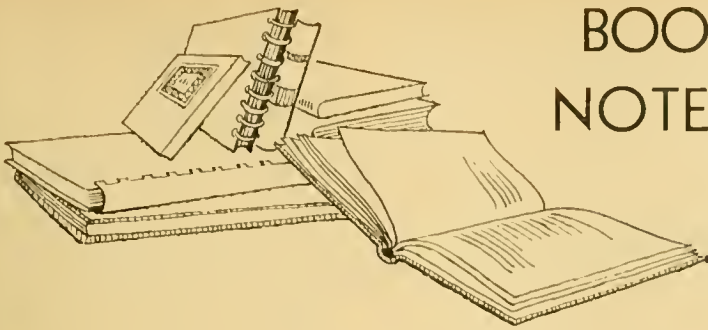
Some compromise

Necessarily, a standard-setting document reflects a consensus—which means compromise and complications for the reviewer. The 1966 "Standards" is not what I would have written; it is possibly not what its author or his consultants would have written individually. It is brief and general. In my opinion, it should be examined by the reader at arm's length—not to determine what particulars seem less than satisfying or have been omitted, but rather to discover the principles appearing in bold relief.

From this perspective the revised "Standards" amply meets the test of time. It clearly sets forth a philosophy, function, and procedures for the court in harmony with the goals of the juvenile court principle. It offers counsel on the crucial matters of organization and administration, staffing, and community relations. It introduces the court novice or curious layman to the mysteries of a beleaguered but useful and exciting institution. And it lies to hand for the judge, his staff, and the citizenry in measuring the quality of local courts and proposing innovations. That it fails to answer all the questions of the experts or to hazard a reading of the future may leave some of us dissatisfied—but just until we realize that this is meant to be only the first cup of tea. Other cups are available, some of them with tea leaves at the bottom.

¹ Department of Health, Education and Welfare, Social Security Administration, Children's Bureau: Standards for specialized courts dealing with children. CB Publication No. 346. 1954.

BOOK NOTES



THE CHILDREN OF THE SOUTH. Margaret Anderson. Foreword by Ralph McGill. Farrar, Straus and Gironx Publishers, New York. 1966. 208 pp. \$4.95.

Few people in Clinton, Tenu., expected serious trouble when their public high school was desegregated in 1956, according to the teacher-guidance counselor who is the author of this book. Speaking from her experience, she says of the first days of integration: "White students greeted . . . Negroes . . . in friendly and informal ways, as they had all their lives. A Negro girl was chosen to be an officer in her class." The school principal said to his staff: "If we can get through the first 2 weeks, we will be all right."

But Clinton did not get through the first 2 weeks without serious trouble. The author describes how outside agitators stirred up mob violence that eventually led to the destruction of a new high school and the need to call in the National Guard.

She also describes how after a new school was built the determination of the community leaders, school board, and school administration and faculty gradually moved the school from self-conscious desegregation nearer to true integration.

The major part of the book, however, focuses on the experience of "these pioneers of the 20th century—the Negro children who had the courage to face hostility, danger, and social isolation day in and day out in an effort to get a better education or to pave the way for others and on the difficulties they encountered not only because of the turbulent school climate, but also because of their background of poverty, the inadequacies in their elementary

education, their low self-esteem, and the extreme pressures on them to succeed." The emotional toll is revealed in the words of the children themselves, as they poured out their feelings to their guidance counselor, the author.

In the last part of the book, the author discusses ways individual teachers in special educational programs might help close the educational gaps between Negro and white children.

Ralph McGill in his foreword says that this book reveals "what the costs of generations of segregation were, and are, to some 20 million Americans."

FREUD AND AMERICA. Hendrik M. Ruitenbeck. The Macmillan Company, New York. 1966. 192 pp. \$4.95.

A distorted view of Freud's theories has influenced both child-rearing practices and education in the United States, the author of this examination of the effects of Freud's teaching in this country maintains. Child-rearing practices were the first to feel Freud's influence, he points out. Soon after World War I, "sophisticated parents," mostly those susceptible to fads, went overboard into permissiveness, ignoring "the stern realism with which Freud looked at human personality." Today, he contends, many children as well as parents are psychology conscious, and children often relate to their parents not only as parents but also as "peers" and sometimes as competitors.

He also attributes many of the failures of education in elementary and secondary schools to the dilution of Freudian theories and to the tendency of many teachers to act as though their chief function is to understand children rather than to help them acquire knowl-

edge and to "learn to handle the intellectual tools which give them command . . . of their culture."

Diluted Freudian thought has also often made programs of psychological counseling in colleges ineffective, the author contends, and he recommends that universities apply psychoanalytic insight more effectively to help students "become more independent persons with more secure identities while they are acquiring their formal general education."

In other sections of his book, the author discusses the effects of Freudian thought and the works of his "forerunners and contemporaries" on religion and life in general in the United States.

THE SCHOOLCHILDREN: growing up in the slums. Mary Frances Greene and Orletta Ryan. Pantheon Books, a division of Random House, New York. 1966. 227 pp. \$4.95.

Written by two elementary-school teachers, this book describes the day-to-day life of 4th-grade schoolchildren and their teachers in two New York City public schools, one in East Harlem, the other in Harlem.

The section on East Harlem describes a teacher's day—what it is like to teach culturally deprived children, some with severe emotional problems, and the reactions of the children to the teacher's authority and to the teaching program, which the authors see as inadequate and in many ways irrelevant.

The report on Harlem tells in the children's own words what they think of themselves, their homes, the school, and the world.

ON AGGRESSION. Konrad Lorenz. Translated by Marjorie Kerr Wilson. Harcourt, Brace & World, Inc., New York. 1966. 306 pp. \$5.75.

The author, a scientist who observes animal behavior, describes the ways in which various kinds of animals handle their innate "intraspecific" aggression—aggression toward members of their own species—and shows how animal rituals that developed because of their survival value tend to become fixated and to be performed for their own sake. He then asserts that the same process has taken place in the cultural and phylogenetic development of man, leaving man in the predicament of having ag-

gressive responses to rituals that not only no longer have survival value but also actually threaten the extinction of the species. He sees the only hope for mankind in an honest recognition of its aggressive instincts and their need to be discharged in some way—either destructively or harmlessly sublimated.

Implying that both the hope and the danger for mankind lie in youth's tendency to develop "militant enthusiasm"—a kind of "object fixation" that does not develop in later life—the author advocates that efforts be made to turn this "militant enthusiasm" toward art, science, medicine, and other interests based on humanistic values, rather than toward national and political causes. This directing, he maintains, cannot be done by education alone, but requires the development of a relation of trust and respect between the generations.

GROUP VALUES THROUGH CHILDREN'S DRAWINGS. Wayne Dennis. John Wiley & Sons, New York. 1966. 211 pp. \$6.95.

Children draw what they admire and their drawings "represent social values," the author of this book maintains. On this assumption, he discusses and interprets over 2,500 drawings of "a man" by school boys from several ethnic groups and most socioeconomic levels in 13 countries.

Nearly all the drawings by boys in the United States, whether they were by white Christians, orthodox Jews, Indians, or Negroes, are of a similar figure—a young, well-dressed, smiling white man, the author says. One of his conclusions, therefore, is that these drawings strongly support "the idea that American culture manages to achieve a uniform set of values. . . ." On the other hand, he found that boys in Japan drew figures in Western clothes but with oriental faces, a fact he interprets to mean that they accept Western ideas but prefer their own faces.

Boys in Europe, the Middle East, and the Far East also tended to draw white men in Western clothes (though more Easterners drew men in native clothes than other groups), but their figures were less often smiling and more often suggested an occupation than those of the American boys.

The author believes his method of

studying cultural values through the drawings of children can be used in both advanced and developing countries, but may be most useful in the latter. He is a psychologist and a professor at Brooklyn College.

BRIEF SEPARATIONS. Christoph M. Heinicke and Ilse J. Westheimer. International Universities Press, New York. 1966. 255 pp. \$8.50.

Ten 2-year-old children studied by the authors of this report on the effects on young children of brief parent-child separation found it hard to reestablish an affectionate relationship with their mothers after separation of from 2 to 20 weeks. The investigators found that none of the children could respond at once to their mothers, though most quickly reestablished a relationship with their fathers. Some children were still hostile to their mothers 20 weeks after reunion. Partly because of this reaction, the authors speculate that it may be the function the parents perform rather than the person the child misses during the separation.

The purpose of the study, according to the authors, was to replicate and extend the findings of an earlier study they had conducted. In discussing the results of both studies, they include the results of studies on the same subject conducted by other investigators.

THE YOUNG NEGRO IN AMERICA: 1960-1980. Samuel D. Proctor. Association Press, New York. 1966. 160 pp. \$3.95.

The Negro has moved through four stages from slavery toward freedom and is in his fifth, according to this discussion of the young Negro and his problems and prospects in the next 20 years. He has gone through social disintegration following the Emancipation Proclamation, alienation from the white man, imitation of the white man, and litigation to obtain his rights. Now, largely through the determined efforts of young Negroes, he is at the base of the fifth stage—integration.

The author maintains, however, that "The young Negro will have to remain committed to integration and not make a psychological nest inside the Negro world to which he may revert when the going gets rough," if the fifth stage is to be completed. He must compete with the white society in every way "to over-

come his educational deficit, change the poverty pattern, and outlive the American stereotype of the Negro." Even under the most favorable conditions, the author asserts, the going will be difficult, and "nothing will resist him more persistently than the economic pressures in American life." He points to the necessity for the various segments of society to work together rather than against each other to effect needed change.

The author was until recently special assistant director of the Office of Economic Opportunity.

THE HAMPSTEAD PSYCHOANALYTIC INDEX: a study of the psychoanalytic case material of a two-year-old child. John Bolland, Joseph Sandler, et al. International Universities Press, New York. 1966. 203 pp. \$4.50.

This monograph describes the case history of Andy, a young child with behavior problems treated at London's Hampstead Psychoanalytic Clinic. The point of the case presentation is to demonstrate how a psychoanalytic index developed at Hampstead can be applied to all cases and its value for research in psychoanalysis. For this reason, the book is divided into two parts. Part I contains Andy's clinical material; Part II follows, step by step, the indexing of the material, according to general case material, ego (general, anxiety, and defenses), instinctual aspects, object relations, superego, symptoms, and treatment.

READINGS FROM CHILDHOOD EDUCATION: articles of lasting value. Margaret Rasmussen, editor. Association for Childhood Education International, Washington, D.C. July 1966. 414 pp. \$3.75.

Forty years (1924-64) of publication are represented in this anthology of more than 80 articles and poems taken from the journal *Childhood Education*. Selected from over 500 contributions, the articles are arranged under 6 headings: beliefs, the child, the teacher, the classroom, past inspirations, and future aspirations. Specific subjects include such topics as an adult's view of children's values; the role of love in preschool education; what creative teaching means; language in childhood; preparing children

for a world society; and the role of education in contemporary life.

A MONTESSORI HANDBOOK. Edited by R. C. Orem. G. P. Putnam's Sons, New York. 1966. 162 pp. \$1.95.

This book contains Maria Montessori's own handbook on her teaching method and up-to-date material on Montessori theory and practice in the United States. Dr. Montessori's material is divided into five sections; each is accompanied by an introduction explaining in laymen's terms the content that follows and by essays discussing

the subject-matter as applied today, written by representatives of medicine, education, and psychology. According to the editor, the book is intended for Montessori practitioners and nonprofessional readers alike.

FOUNDATIONS FOR MARRIAGE AND FAMILY RELATIONS. Dale L. Womble. The Macmillan Company, New York. 1966. 449 pp. \$7.95.

Successful marriage is neither a "gift nor an accident," but, rather, a "hard-earned achievement," according to the author of this text on preparation for

marriage and family life for unmarried college students. He sees marriage preparation courses as a means of helping college students develop "a basic philosophy about marriage and family relations" consistent with the goals of our democratic society.

The 21 chapters contain material on such topics as courtship, preparing for marriage, legal requirements, sexual harmony, mixed marriages, husband-wife relationships during pregnancy, rearing children, and understanding family counseling. Each chapter concludes with a summary and lists of questions "for further thought" and suggestions for further reading.

films on child life

Charges for rental or purchase may be obtained from distributors.

CHILDREN IN THE HOSPITAL. 44 minutes; sound; black and white; borrow, rent, or purchase.

This film shows the behavior of 4- to 8-year-old normal children with acute medical problems in a city hospital as they react to the stress of hospitalization, illness, and temporary separation from their families.

Audience: Doctors, nurses, social workers, psychologists, and, with a professional discussion leader, undergraduate students, hospital volunteers, parent discussion groups, and selected lay groups.

Produced by: Edward A. Mason, M.D.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, Ill., 60604.

THEY NEED THESE DAYS—DAY CARE FOR CHILDREN. 25½ minutes; sound; color; rent or purchase.

Describes a modern day-care program for 3- to 5-year-old children of working parents in a Minnesota community, pointing out the importance of providing preschool children with opportunities to learn and to develop healthy social relationships.

Audience: Inservice and preservice

social workers, nursery school specialists, teachers, churches, intergroup organizations, and parents.

Produced by: James Liebling, University of Minnesota, for the Child Welfare Division, State Department of Public Welfare, St. Paul, Minn.

Distributed by: Audio-Visual Education Service, University of Minnesota, 29 Westbrook Hall, Minneapolis, Minn., 55455.

THE PHENOMENA OF EARLY DEVELOPMENT. 13 minutes; sound; black and white; loan.

This film depicts the development of motor skills in a normal infant during three periods of infancy—3 to 6 months, 6 to 9 months, and 9 to 12 months. It is accompanied by an illustrated booklet with similar text which also discusses development in the infant's second year.

Audience: Instructors and students in child growth and development; persons conducting lectures or group discussions for nursing education, public health nursing, and medical student instruction.

Produced by: Ross Laboratories.

Distributed by: Ross Laboratories, Columbus, Ohio, 43216.

PKU—PREVENTABLE MENTAL RETARDATION. 15 minutes; sound; color; borrow, rent, or purchase.

This film illustrates through case histories the importance of detecting and treating phenylketonuria early in infancy to prevent mental retardation. It documents the progress of selected patients by repetitive sequences obtained at various times in their lives from 6 weeks to 3½ years of age. In addition, it presents general data about the disease concerning the signs and symptoms that suggest its presence.

Audience: Nurses, public health workers, physicians, and parents.

Produced by: International Film Bureau, Inc.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, Ill., 60604.

A NEW LIFE FOR JENNIFER. 27 minutes; sound; color; loan.

Depicts the work of the Detroit Lutheran School for the Deaf in helping deaf children to lip-read, to speak, and to acquire a language foundation necessary for meaningful communication and learning.

Audience: Parents, religious organizations, and professional persons interested in or working with deaf children.

Produced by: Portafilms, Drayton Plains, Mich.

Distributed by: Lutheran School for the Deaf, 6861 East Nevada Avenue, Detroit, Mich., 48234.

HERE and THERE



Federal legislation

On November 3, the President signed into law amendments to the Elementary and Secondary Education Act of 1965. In addition to making some administrative changes, the amendments authorize:

- A new program of grants to the States for education of the **mentally and physically handicapped**, to supplement and increase, but not supplant, the level of State, local, and private funds expended for this purpose. Appropriations of \$50 million and \$150 million are authorized for this program for fiscal years 1967 and 1968 respectively.

- Aid to schools operated by the Bureau of Indian Affairs and to local educational agencies for the education of out-of-State Indian children, through funds allotted by the Commissioner of Education to the Secretary of Interior.

- Inclusion of children in foster homes and institutions for neglected and delinquent children in the child population counts on which payments to the States and local educational agencies are based under title I of the act (provisions for aid to school districts containing concentrations of low-income families).

The Demonstration Cities and Metropolitan Development Act of 1966 was also signed by the President on November 3. Among other provisions, the act authorizes the Secretary of Housing and Urban Development to make grants and provide technical assistance for:

- Comprehensive demonstration programs in cities of all sizes "to rebuild or revitalize large slum and blighted areas; to expand housing, job, and income opportunities; to reduce dependence on welfare payments; to improve

educational facilities and programs; to combat disease and ill health; to reduce the incidence of crime and delinquency; to enhance recreational and cultural opportunities; to establish better access between homes and jobs; and generally to improve living conditions for the people who live in such areas. These objectives are to be accomplished through "the most effective and economical concentration and coordination of Federal, State, and local public and private efforts." Grants are to be made to comprehensive city demonstration agencies of up to 80 percent of the costs for planning, developing, and administering the programs. The law authorizes appropriations of \$12 million in planning funds for each of the fiscal years 1967 and 1968, and \$400 million for fiscal 1968 and \$500 million for fiscal 1969 for carrying out the program.

- Assistance to planned metropolitan development projects in the form of supplementary grants to State and local public bodies already engaged in such projects, not to exceed 20 percent of the cost. Appropriations authorized are not to exceed \$25 million for the fiscal year 1967 and \$50 million for fiscal 1968.

Another act signed by the President in early November provided the District of Columbia with a **mandatory reporting law** in relation to child abuse. The law requires physicians and hospitals in the District to report cases of suspected physical abuse of children under 18 years old to the police department and provides for immunity from liability to judicial proceedings for the reporting persons or institutions.

With this law, the District joins the 49 States having laws to encourage the reporting of child abuse. Hawaii

is the only State with no abuse reporting law.

Health manpower

The Nation's hospitals need 20 percent more professional, technical, and auxiliary workers than they now have if they are to give optimum service to patients, according to the findings of a recently completed survey carried out jointly by the American Hospital Association (AHA) and the U.S. Public Health Service (PHS). On the basis of their findings, the two agencies estimate that hospitals now employ 1.4 million professional and technical workers and need 275,000 more to provide optimum patient care.

The agencies found the following: The most urgent need is for professional nurses—hospitals need about 83,300 more than they now employ. Next greatest need is for nursing aides, orderlies, and attendants—about 48,700 more in general hospitals and another 31,300 more in psychiatric institutions. And the next need is for about 42,800 more practical nurses and about 6,400 more social workers than the 12,100 they now employ.

These estimates are based on data from 4,600 of the 7,100 hospitals registered by AHA. A complete report on the study will be available in the next few months.

Two conferences on the potential place of midwifery or nurse-midwifery in obstetrical programs in the United States took place last fall. The first held in Princeton, N.J., on October 24-25, was under the sponsorship of the Josiah Macy, Jr. Foundation and brought together about 25 specialists in obstetrics, pediatrics, maternity nursing, nurse-midwifery, and demography from the United States and other countries. At this conference it was pointed out that the United States was the only leading country in the world where midwives are not used extensively in medical care. One focus of the discussion was whether or not the more extensive use of midwives could help reduce the high infant mortality rates in some parts of this country or alleviate the severe shortages in health manpower. No consensus in viewpoint emerged.

The second conference on the subject was the third nursing roundtable sponsored by Ross Laboratories and was

held in Columbus, Ohio, on November 7. Ten maternity nurses and nurse-midwives from universities and professional organizations attended. With the purpose of initiating a dialogue between the two specialties represented, the participants presented papers giving an overview of maternity nursing and nurse-midwifery in the United States and discussed differences in points of view separating the two groups. The chairman was Edith Anderson, consultant in nursing education for the Children's Bureau.

Full proceedings of both conferences will be published soon by the sponsoring agencies.

Juvenile delinquency

In 1965 about 697,000 juvenile delinquency cases, excluding traffic offenses, were brought before the Nation's courts, according to Children's Bureau estimates based on data received from reporting courts. This number represents an increase of 2 percent over the previous year. In the same period, the number of children aged 10 through 17 increased only 1 percent. This continues the upward trend in juvenile delinquency cases that has prevailed since 1949, a trend broken only in 1961. Altogether, between 1957 and 1965, juvenile delinquency cases increased 58 percent—almost double the increase in the population of children aged 10 through 17 during the same period.

Most of the overall increase in 1965 over 1964 was accounted for by an increase in cases involving girls. These went up 8 percent during the year while the number of cases involving boys remained comparatively stable. However, as in past years, four times as many boys as girls were brought to court, and for different reasons. Boys were referred most often for offenses against property; girls, for misbehavior such as running away and "ungovernable behavior."

A 12-percent decrease in juvenile delinquency cases occurred in 1965 in courts in rural areas. This decrease, however, had little effect on the overall trend since urban courts handle more than two-thirds of all delinquency cases in the country.

The number of traffic offenses handled by juvenile courts also increased in 1965, by 4 percent. In rural courts, the increase in traffic cases was 19 per-

cent. In all, city and rural courts handled about 460,000 traffic cases involving 397,000 different children.

The courts also handled an increased load of dependency and neglect cases in 1965—157,000 cases, or 5 percent more than in the previous year.

These data and other statistics on children's court cases are presented in the publication "Juvenile Court Statistics—1965" (CB Statistical Series No. 85), issued by the Children's Bureau. Single copies may be obtained without charge from the Bureau.

More than 900 adults in contact with juvenile delinquents because of their "position" as fathers, mothers, teachers, policemen, or probation officers defined their own and each others' roles in the prevention of juvenile delinquency in different terms when questioned by researchers at the Youth Studies Center of the University of Southern California for a recent study, conducted by Alexander W. McEachern and Edward M. Taylor, with support from the Children's Bureau. The adults surveyed agreed that parents have the prime responsibility for preventing delinquency, but they did not agree on what adults in each category of position should do or actually do in specific situations or on what might be an effective action.

Each of the adults queried was in one of the five authoritative positions in relation to a sample of 259 juveniles referred to probation departments in Southern California. They were asked to give their opinions of specific adult actions toward children involving three types of adult behavior—physical manipulation, transferral of information, and demonstration—in relation to whether the actions were appropriate, actual, or effective behavior for an adult in their own position and for adults in the other four positions.

In each category of adults, a lack of consensus was found not only in relation to the appropriate, actual, or effective behavior of adults in the other categories, but also in relation to the respondents' own category. However, the differences were more marked between positions than within them.

Such disagreements in the way adults see adult behavior toward juveniles, the investigators conclude, seem to arise more from differences in the institutions the adults represent than from differ-

ences in personalities; nevertheless they result in confusing inconsistencies in expectations and goals for young people.

The investigators recommend that society set up general expectations for each role the child must take and not concentrate on problems that arise when a child does not meet the expectations different kinds of adults have for him.

Handicapped children

An analysis of consonant sounds produced by persons with oral clefts can be used to show a wide range in their speech ability, to determine the details impairing intelligibility of their speech, to evaluate changes in speech following treatment, and to compare their speech with the speech of normal persons, according to a study recently completed by the Department of Speech and the Speech Clinic at the University of Michigan. The study was conducted by T. David Prins and H. Harlan Bloomer with a research grant from the Children's Bureau.

The investigators analyzed the speech of 20 boys with oral clefts, aged from 9 to 18, enrolled in a residential program of speech therapy. As part of the study, each boy made a sound recording of a 50-item word list before and after treatment. While listening to the recordings, untrained listeners wrote down either the entire word they thought they had heard or its initial consonant. Although individual listeners varied considerably in responding to identical word lists on different occasions, the listeners as a group showed good stability in scores representing mean percent of error, the distribution of error across phoneme classes, and the type of error as a function of phoneme class.

Four new research projects on handicapped children are included in recent awards made by the Children's Bureau for research in maternal and child health:

- University of California at Los Angeles, to study the use of a response computer in testing deafness in infants before they are old enough to respond to standard tests (\$16,690).

- University of Washington, Seattle, to study the effectiveness of a multidiscipline team method in providing services to patients in clinics for handicapped children (\$52,142).

• American Institute for Prosthetic Research, to study a pneumatic arm prostheses (\$65,621).

• University of Illinois-Chicago Medical Center, to develop a research design for studying children with multiple handicaps (\$76,798).

Against rubella

A test by which a physician can tell within 3 hours whether a patient is immune to rubella (German measles) was recently released to hospitals, public health departments, and diagnostic laboratories by the developing agency, the National Institutes of Health (NIH), U.S. Public Health Service. Scientists at NIH report that the test is simple, fast, sensitive, reliable, and inexpensive and that it can be used to detect whether or not immunity exists even years after infection.

The new test, called hemagglutination-inhibition (H-I), is expected to speed up the development of vaccines against rubella now under study at NIH and in private laboratories. If so, a vaccine may be available within the next 3 years—before the expected appearance of another rubella epidemic such as the one in 1964, which impaired the development of about 20,000 unborn babies of women who contracted the disease in pregnancy. With the new test, researchers can determine more rapidly than with earlier tests the effectiveness of experiments with attenuated virus preparations, with which they are now working.

NIH scientists also point out that the new test can now be used on pregnant women who have been exposed to rubella to determine whether there is cause for concern or whether the patient is immune to the disease and her unborn child therefore at no risk; and that after the vaccine has been developed, women can be tested before marriage and inoculated against rubella if they are not already immune.

During the first year of a 5-year special project begun in 1965 on the effects of rubella contracted before birth, the Baylor University College of Medicine found that infants showing the symptoms of congenital rubella can be diagnosed positively as having been infected with the disease and that the resulting impairment can be distinguished from

congenital impairment from other causes. Such symptoms include defects in vision and hearing; retardation in adaptive ability and in motor and language development; cardiac disease; and low birth weight.

The project has coded information on 96 infants, most of whose mothers contracted the disease in the epidemic of 1964. The infants showed the following specific effects: 26 had defects in vision and hearing; 9, defects in vision only; 33, mild or severe hearing defects only; and 71, cardiac disease. In addition, the birth weights of most were low, and 25 percent were still harboring rubella virus at 12 to 15 months of age. Of 126 infants originally selected for study, 20 died during the first year.

During the second year of the project, now in progress, the researchers will continue to follow the natural history of the disease and to provide medical services to these children. In addition, they are working toward developing an experimental model program using medical and community facilities for 150 children born with the symptoms of rubella. Of these children, the researchers expect that 98 will have defects of hearing; 44, defects in both hearing and vision; 90, defects in vision only; and 108, cardiac disease.

The project is receiving Federal support through a grant from the Children's Bureau.

Infant mortality

A recent investigation by the Children's Bureau, in cooperation with the Maternal and Infant Health Computer Project at George Washington University, of infant mortality levels in the more than 3,000 counties in the United States in the 5-year period 1956-60 revealed that 90 percent of the counties had infant death rates in excess of 18.3 per 1,000 and 10 percent had rates of 18.3 or lower. On the basis of these findings, the Bureau has estimated the number of "excess infant deaths" for each of the higher rate counties. The excess number was defined as the difference between the actual number of infant deaths in the county and the expected number if the 10th percentile rate—18.3 deaths of infants under 1 year per 1,000 live births—had held.

This analysis indicated that during the 5-year period 169,784 infant deaths occurred in the United States in excess

of what would have occurred had the 10th percentile rate prevailed. Well over one-third of these excess infant deaths were concentrated in 56 counties, nearly all of which were metropolitan. On the other hand, counties with infant death rates as low as or lower than the 10th percentile county rate were with few exceptions without urban areas with populations as large as 50,000.

Inservice training

"Meeting the Needs of Children Through Social Services," a series of 12 films and guides for discussion leaders used in South Carolina last year as part of an inservice training program for public welfare workers is now available from the Department of Film Services at the University of Tennessee (Knoxville). Both the films and guides were produced jointly by the University of Tennessee School of Social Work, the South Carolina Department of Public Welfare, and the South Carolina Educational Television Network. The project was supported in part by a child welfare training grant from the Federal Children's Bureau.

The films run for 30 minutes each. They illustrate such topics as social development in children, professional casework relationships, interviewing, and helping one-parent families. The guides were prepared for persons selected to lead discussion groups after a viewing of the films.

The films were telecast last year, once a week, over South Carolina's closed-circuit television system to all county social service staff members. Trained leaders led the ensuing discussions.

Under a 2-year career development program, four recent graduates of schools of social work are now working with the Bureau of Family Services of the U.S. Welfare Administration as interns in public welfare administration. For the first year they will be attached to the central office in Washington, D.C., and are now on assignments in the Bureau's Division of Program Operations. For the second, they will be assigned either to a division in the central office or to one of the nine regional offices according to fields of interest, positions available, and geographic preference. During their

internship they will have opportunities to work with State and local public welfare agencies and opportunities for field experience as needed.

The Bureau expects eventually to have openings for 6 to 10 interns each year and plans to select candidates again next spring. Though it does not require applicants to have professional experience, it will give preference to those who do have experience, and it does require the intern to have a master's degree in social work by the time he comes on the job.

At the end of the 2 years, the interns will be ready to enter careers in some field of public welfare administration.

Child welfare services

On March 31, 1965, about 697,300 children were receiving services from public and voluntary agencies and institutions, the greatest number on record, according to reports received by the Children's Bureau. This represented a 7-percent increase over the number being served on the same date the previous year.

Of these children, 69 percent were being served primarily by public agencies and institutions; 31 percent, by voluntary. About 42 percent were living with parents or relatives; 30 percent, in foster family homes; 16 percent, in institutions; 10 percent, in adoptive homes; and 2 percent, under other kinds of arrangements.

The greatest increase was in the number of children served by public welfare agencies: an increase of 29,000 children, or 13 percent, in their own homes; of 16,800, or 8 percent, in foster care; and of 2,900, or 9 percent, in adoptive homes. The services of voluntary agencies rose substantially only for children being served in adoptive homes: 2,100 children, or 7 percent, more than on the reporting date in 1964.

For a fuller analysis of child welfare services, facilities, expenditures, and personnel, see "Child Welfare Statistics—1965" (CB Statistical Series No. 84). Single copies are available from the Bureau without charge.

Foster care

Between March 31, 1961, and the same day in 1965, the number of children under 18 years old in foster care under public or voluntary agencies rose

COMPARATIVE INFANT MORTALITY		
Country	Rate per 1,000† 1962-64	Percent change 1962-64 from 1961-63
Sweden.....	15.0	-3.2
Netherlands.....	*15.8	-4.8
Norway.....	*17.1	-3.9
Finland.....	*18.5	6.6
Denmark.....	*19.3	-4.9
Australia.....	19.7	-0.5
New Zealand.....	19.7	-5.8
Switzerland.....	20.2	-3.4
United Kingdom.....	*21.6	2.3
Japan.....	23.3	-10.4
United States.....	25.1	-0.8
Canada.....	26.1	-3.3
Federal Republic of Germany.....	*27.1	-7.2
Ireland.....	*27.5	-4.2
Luxembourg.....	29.5	+3.1

†Deaths of infants under 1 year per 1,000 live births
 *1964 data provisional
 Source of data: Demographic Yearbook, 1964, Statistical Office of the United Nations, New York

The United States infant mortality rate in the 3-year period 1962-64 ranked 11th in a selected group of 15 countries. These are countries with advanced economies, with populations (1960) of at least 300,000, and with well-developed vital record systems, conforming to the World Health Organization's definitions. Among the same countries, the U.S. rate for the period 1961-63, as well as in 1960, was in 10th position as compared with 6th in 1950.

The apparent shift in position of the U.S. rate results from faster pace of reduction of infant mortality in other countries; for example, between the two periods (1961-63 and 1962-64), about a 10-percent reduction in the infant death rate was accomplished in Japan while for the United States the decrease was under 1 percent. Other countries, with rates already lower than that of the United States, made more rapid decrease.

—Eleanor P. Hunt

from 246,500 to 287,200, according to a recent Children's Bureau analysis of figures received from the States. If the increase continues at this pace, by 1975 about 364,000 children under 18—4.7 per 1,000—will be in foster care of some type.

The figures show that in recent years the number of children in foster care under agency auspices has steadily increased, following a period of decline. The number dropped after 1933, and the level for that year was only reached again in 1961-62. The rate of foster care also dropped substantially after 1933, but it has slowly risen in the last several years. The rate for 1965 is two-thirds of the 1933 rate. If the

rate prevailing in 1933 had continued, an additional 136,000 children would have been in foster care in 1965.

Since 1933 and 1950, there has been a decided shift from institutional to foster family care. On March 31, 1965, about 207,500 children under 18—or 2.9 per 1,000—were in foster family care as against 79,400, or 1.1 per 1,000, in institutional care. Those in foster family care were for the most part (78 percent) under the care of public agencies; those in institutional care for the most part (86 percent) under voluntary agencies.

Foster care under public auspices, in terms both of number and rate of children in care, has risen consistently

since 1933; at the same time, foster care under voluntary agencies or institutions has decreased, the number of children in voluntary care in 1965 being 36 percent below the 1933 level.

Statistical tables and a more detailed analysis are available in the recent publication "Foster Care of Children: Major National Trends and Prospects," prepared by Seth Low. Single copies are available on request from the Children's Bureau.

The Wurzweiler School of Social Work, Yeshiva University, New York, in its 1966-67 winter session is conducting a pilot project in the training of foster parents. The foster parents will be selected by the public and voluntary agencies in New York City.

The emphasis will be on child growth and behavior and on the special development of the relationship between parent and foster child.

Courses for three groups of foster parents will be held at the university. Each group will consist of eight foster-parent couples. Two will be for one semester and one for two semesters. The plan also provides for prior and post-training sessions for agency supervisors and caseworkers to increase their effectiveness in ongoing agency training of foster parents.

The purpose of the project, which is supported by a training grant from the Children's Bureau, is to demonstrate a pattern for the collaboration of child-placement agencies and schools of social work which might be adopted elsewhere.

Adoption

Parents who adopt a child over 5 years old appear to run little more risk of having the adoption fail than those who adopt younger children, according to a study recently completed by the University of Wisconsin School of Social Work, under the direction of Alfred Kadushin. The project was largely supported by a grant from the Children's Bureau. The 4-year study of 91 children adopted after they were 5 (but before they were 12) and their adoptive parents found that over three-fourths of the parents were satisfied with the adopted child, though most of them had originally wanted younger children.

Most of the children involved in the study came from homes in which they

had been badly treated and from which they had been removed by court order. To cut down the variables, the study considered only white children with normal physical and mental health. All of the adoptive parents were from higher socioeconomic levels than the natural parents, and most were older than the parents who usually adopt infants.

The study found that much of the success of the placement rested on the degree to which the parents accepted the adopted child and that many of the children showed a "biological resiliency" that helped them make wholesome responses to a change in environment.

Nutrition

About 70 public health nutritionists and dietitians from 27 States attended a 4-day workshop in Kansas City, Mo., in early October, on nutrition services in maternity and infant care projects and comprehensive health services for children and youth. Sponsored by the Children's Bureau and the Division of Health of the Missouri State Department of Public Health and Welfare for the States covered by Regions I, II, V, VI, VIII, and IX of the Department of Health, Education, and Welfare, it was the first of two national workshops planned to improve and extend nutrition services in such projects. The second will take place in New Orleans in February.

The discussions focused on such questions as: the main nutritional factors contributing to a high-risk pregnancy; current knowledge of nutritional requirements during pregnancy and ways of meeting these needs on a subsistence income; nutritional needs of the pregnant adolescent girl and ways of motivating adolescents to accept a nutritionally adequate diet; the problem of iron deficiency anemia in infants; the dangers of overnutrition (caloric) in relation to weight gain and growth in infants and young children; and methods of interviewing, reaching subcultural groups, keeping appropriate clinical records, and preparing reports on nutrition.

A 3-member panel of nutritionists from maternity and infant care projects in Minneapolis, Minn., Portland, Oreg., and Cincinnati, Ohio, described a nutritionist's role in a multidisciplinary

team; coordination of nutrition services with other community programs such as public assistance and the food stamp plan; and the use of home economists in training neighborhood leaders as nutrition aides to teach small groups of mothers.

Among recent grants for research in the field of maternal and child health made by the Children's Bureau were three to support new research on nutrition. The three grants were awarded to:

- Children's Hospital Research Foundation, Columbus, Ohio, for a study of malnutrition among children from 1 to 6 years old in low socioeconomic areas (\$159,860).

- Michael Reese Hospital, Chicago, Ill., for a study of intra-uterine malnutrition (\$36,930).

- The Food and Nutrition Board, National Academy of Sciences-National Research Council, Washington, D.C., to consider special problems in current maternity and infant care programs and to develop up-to-date guidelines for providing nutrition in maternal health.

Education

About 56 million children and young people were enrolled in public and private schools and colleges in the United States last fall—a 2.6-percent rise over 1965—if estimates made last summer by the U.S. Office of Education hold true.

The largest proportion increase was expected to be in colleges and universities: 6 million, or 9.1 percent, over fall 1965. High school enrollment (grades 9 through 12) was expected to rise to 13.3 million, an increase of 2.3 percent; grade school enrollment (kindergarten through grade 8) to 36.6 million, an increase of 1.7 percent.

To teach these students, the Office of Education estimates colleges and universities need 466,000 instructors, 8.6 percent more than last year; grade and high schools, 2,045,000 teachers, 4.1 percent more than in the previous year.

In the 1966-67 academic year, the schools are expected to spend about \$48.8 billion as against \$45 billion spent in the fiscal year 1965-66. In the latter year the Federal Government contributed \$6.1 billion in grants to schools at all grade levels, more than 2½ times the Federal contribution in 1963-64.

These and other figures are contained in two forthcoming publications of the Office of Education: *Digest of Educational Statistics* and *Projections of Educational Statistics*. According to the *Digest*, more than 70 percent of the young people in this country who are in their 20's have had a high school education.

Elected by their fellow villagers for training as teachers for Project Head Start, 50 Alaskan "natives"—Eskimos, Aleuts, and Athapaskan Indians—are presently serving as teachers in programs for preschool children set up in their villages. None of them had taught before, and several have had no more than a fourth-grade education; but all were chosen as persons who work well with children.

Before taking up assignments with Project Head Start, the 50 prospective teachers completed an 8-week training course at the University of Alaska in subjects preschool teachers need to know about such as nutrition and arts and crafts. Teaching supervisors will visit each village project regularly

to help these teachers improve their competence.

Last year, the Alaska State Community Action Program was unable to fill the demand from village councils for help in establishing preschool programs because of the lack of preschool teachers in the area. Through the new program, about 35 village projects were set up this past fall.

Rehabilitation

A national Commission on Accreditation of Rehabilitation Facilities was established last July by the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP) to develop improved standards for rehabilitation facilities. The commission consists of a nine-member board of trustees: three each from ARC and NASWHP and three chosen at large by the other six members.

The specific objectives of the commission are: (1) to promote and assist in the self-improvement of rehabilitation facilities by providing educational and advisory services; (2) to adopt

standards for measuring rehabilitation facilities for accreditation; (3) to publish lists of rehabilitation facilities meeting the commission's standards; and (4) to promote and conduct studies that will improve the initial standards.

The plan is endorsed by the U.S. Vocational Rehabilitation Administration.

Correction

In Van G. Hromadka's article, "Toward Improved Competence in Child-Care Workers: I. A Look at What They Do" (*CHILDREN*, September-October 1966), the inadvertent omission of a "not" from a sentence describing one criterion for selecting the 12 institutions under study unfortunately reversed the facts. The sentence beginning at the bottom of the first column on page 181 should have read: "A major basis for selection was that the institution had not less than 30 percent of its population under clinical treatment for emotional disturbance. . . ."

guides and reports

HELPING CHILDREN IN INSTITUTIONS: a report on 26 courses for child care workers. Eva Burmeister. Federation of Protestant Welfare Agencies, 281 Park Avenue South, New York, N.Y., 10010. 1966. 51 pp. \$1.

Describes and evaluates the basic and advanced courses for institutional child-care workers in the New York area conducted from 1957 through 1964 under the auspices of the Hunter College School of Social Work and the Federation of Protestant Welfare Agencies.

EARLY CHILDHOOD: crucial years for learning. Margaret Rasmussen and Lucy Prete Martin, editors. Association for Childhood Education International, 3615 Wisconsin Avenue

NW., Washington, D.C., 20016. 1966. 89 pp. \$1.25.

Contains reprints of 22 articles from *Childhood Education* on the relation of nursery school and kindergarten education to the intellectual and social development of young children.

DIRECTORY OF MATERNITY HOMES AND RESIDENTIAL FACILITIES FOR UNMARRIED MOTHERS: a guide for use and selection. National Council on Illegitimacy, 44 East 23rd Street, New York, N.Y., 10010. May 1966. 206 pp. \$1.50. Discounts on quantity.

The first revision of this directory since 1960, this edition includes in addition to brief descriptions of tradi-

tional maternity homes, lists of the other types of facilities they use—foster family homes, mutual service or wage homes, and group homes.

HELPING HANDS: volunteer work in education. Gayle Janowitz. University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill., 60637. 1966. 125 pp. \$1.75 paperback; \$3.95 cloth-bound.

A guide for the organization and operation of afterschool study centers for underachieving children and the use of volunteers as tutors, based on experience in a tutorial project financed by the U.S. Office of Education.

STANDARDS AND GOALS FOR METHODIST AGENCIES SERVING CHILDREN AND YOUTH. Board of Hospitals and Homes of The Methodist Church, 1200 Davis Street, Evanston, Ill., 60201. 1966. 83 pp. \$1.50.

The second revision of a publication originally issued in 1956.

IN THE JOURNALS

Service and aid

The goal of the social reformers of the early 1900's who worked for the establishment of a Children's Bureau in the Federal Government to integrate "all public services and aid for families and children of all classes" was lost sight of in the 1930's when new financial aid and service programs were put under separate administrations by the Social Security Act, writes Archie Hanlan in the November 1966 issue of *Child Welfare*. ("From Social Reform to Social Security: The Separation of ADC and Child Welfare.") Presenting a historical account of the creation of the Bureau in 1912 and of the events that preceded the enactment of the Social Security Act in 1935, he asserts that the unifying role envisioned for the Children's Bureau became obscured by the pressures to meet the economic crisis. The multiplication of Federal programs in recent years has made the need for relating aid to service programs more urgent than ever, he says.

Maintaining that there is a silence among social workers today in comparison to their vocal espousal of an integrated Federal aid and service program in the early 1930's, he attributes this silence to skepticism toward the "sudden wooing of the poor." Even if a unified aid and service program came about "at this late date," he fears that it will only mask "society's failure to come to grips with poverty in the midst of affluence."

Stability in delinquency

One reason why studies on the use of the casework method in working with juvenile delinquents indicate such poor results may be that society tends to push the young person who commits delinquent acts into a "stable role" as a delinquent, William P. Lentz maintains in the October 1966 issue of *Social Work*. ("Delinquency as a Stable Role.") He points out that everyone

around the young person who commits a delinquent act—parents, friends, teachers, policemen, and social workers—whether they are sympathetic or disapproving, treat him as a delinquent, and that the caseworker is, therefore, at a disadvantage in trying to set up a one-to-one relationship.

Accepting this fact—that the social climate tends to push the young person into a "stable role" as a delinquent—may help social workers reshape their efforts, the author suggests. It is his contention that if the system does not change—and he sees no change in the offing—improvement in the results of casework is not likely. He concludes, therefore, that the problem of "role stability" will continue to hinder efforts to help young people who commit delinquent acts until agencies are able to minimize the "situations that contribute to the development of the stable role" and to lend their support to "proposals that will lead to change."

Effects of hospitalization

Reporting in the October 1966 issue of the *American Journal of Orthopsychiatry* on the preliminary findings of a study of the effects on families of the hospitalization of parents in a mental hospital, Elizabeth P. Rice and Sylvia G. Krakow point out that, though the families studied faced many problems in child care, few tended to call on community agencies at the time of admission. ("Hospitalization of a Parent for Mental Illness: A Crisis for Children.") However, they report, these families seemed to welcome help from community agencies when it was offered.

The study was conducted at a State mental hospital in Massachusetts using 40 patients and their families as demonstration cases and 59 patients and their families as control cases. Demonstration families were assigned to agencies for continuing services; control families were given no special attention.

The problems in child care were

greater when the patient was the mother and when the children were very young, the authors report. In some cases, the return of the patient to the home brought on additional problems if the mother was not ready to take on her duties. Homemaker services proved valuable in supporting both relatives caring for children and parents.

The authors maintain that the study demonstrated the "value of having a social worker at the point of admission to refer families with child-care problems to appropriate community agencies" and that "additional methods and skills appear to be required to achieve adequate protection of children with mentally ill parents either at home or in the hospital."

Migrant children

The greatest service the physician working with the children of migrant farm families can do for migrant children is to stimulate his community to act on their behalf, writes Earle Siegel, M.D., in the October 1966 issue of *Clinical Pediatrics*. ("Migrant Families: Health Problems of Children.") To meet the complex needs of these children, the community must invest in programs of education, social welfare, and medical services, he maintains.

The first need of the parents in migrant farm families is for day-care centers at which they can leave their children during the long workday, says the author. The health provisions made in these centers depend on local needs, interests, availability of facilities, and professional services, he points out.

He concludes that a physician, working with the director of a day-care center for the children of migrants, a public health nurse, and lay volunteers, can make an indispensable contribution toward meeting the children's needs, by designating the tests to be made; planning and supervising an immunization program; suggesting ways of improving feeding habits; and drawing the community's attention to the long-range effects on children in migrant farm families of growing up in extreme poverty and ignorance.

photo credits

Frontispiece, Carl Purcell, National Education Association.

Pages 27 and 29, Tadder, Baltimore.

READERS' EXCHANGE

BRITAIN: *Start with the parent*

As Dr. Britain's review indicates, investigators and clinicians working with the "culturally deprived child" struggle with the problem of providing the protective and pleasure enhancing values so often absent in a slum environment. ["Preschool Programs for Culturally Deprived Children," Clay V. Brittain, *CHILDREN*, July-August 1966.] Many believe that this can be accomplished in the classroom, but our clinical experience indicates that an educational program must be predicated on the values of the home to succeed.

In a psychoanalytically oriented study of nursery school children from an extremely low socioeconomic area, we found that a child, by association, will value what he knows or assumes is of value to the caretaking adult and ego-ideal. Thus, the primary effort must be to modify the value system of the culturally deprived home in consonance with the concept of a unified, integrated, and strong social order that emphasizes self-preservation and the preservation of a democratic society.

In addition to working with the values of the parent or parent surrogate, however, one must make him aware of the communication problems inherent in the child-parent relationship. What the child values is determined by his interpretation of parental values. Hence, the child must understand parental values as accurately as possible as these are modified.

We must also recognize the communication problem between the parent and the therapist. For example, the parents' affirmation that "education is good" may not mean what the educator may mean by that phrase. The mother of our nursery child might say, "If my child learns to read and write well, he can get a job that will pay him a better wage." We believe that education should improve the child's capacity for communication, interpersonal relation-

ships, and better understanding with greater participation in community life.

Britain's review of the studies of preschool enrichment programs seems to indicate that the focus on classroom activity failed to produce any significantly lasting results. We think that introducing a reorientation of values in the home regarding education and society is the most effective way of influencing the child to place value on the enrichment program and enable him to retain and use it.

Henry H. Fineberg, M.D.
*Illinois State Pediatric Institute
Chicago*

FINE: *Same questions*

Regina V. Fine's article, "Moving Emotionally Disturbed Children from Institution to Foster Family" (*CHILDREN*, November-December 1966), is a sound contribution to the practice literature on the placement of children. She is careful to move children, not abruptly, but through sequential steps, smoothly combining old and new contacts; not arbitrarily, but with explanation and preparation; not as passive objects, but with encouragement to abreact their thoughts and feelings. Above all, Mrs. Fine refreshingly admits that she makes mistakes!

On another level of analysis—namely, the community planning level—I was troubled by the following:

1. Institutions decide to part with children. Why? Why can they not arrange living facilities under single administrative auspices?

2. In moving children who require therapy from an institution to a foster home, why is it necessary for the child to break off relationships with one therapist and form new relationships with another therapist?

3. A child runs away. The foster parents are ready to take the child back and work the problem through. Why does his running away become a reason

for returning him to his former institutional placement?

4. Children who live in residential treatment institutions are apparently not geared to master life in normal families. Why not? Why can't this be built into the residential treatment institutional programs prior to replacement into foster homes?

These questions are troubling because they illustrate the degree to which societal and institutional procedures and constraints sometimes severely restrict the practitioner's flexibility in helping his client. It is time to recognize that institutional arrangements were not made in heaven, and that if children are to be helped, resources should be built around them, rather than the reverse.

Norman Herstein
*Executive Director, Jewish Family
and Children's Service
Boston, Mass.*

A challenge to skill

To those of us who, like Regina V. Fine, have the task of helping emotionally disturbed children move from residential settings to foster family care, her article brings a statement of familiar problems that challenge our best diagnostic and treatment skill.

Her article not only describes a developing specialized function of agencies serving children, it also indicates the needs for greater sharing of information and better communication within the social work profession—as well as among the professions—in implementing the placement process.

Residential centers for the psychiatric treatment of emotionally disturbed children are finding that foster family care and group homes are necessary to the total therapeutic milieu. They enable the child to experience community living in a supervised, structured setting. This fact was recognized at the Children's Study Home in Springfield, Mass., soon after its reorganization into a residential treatment center for emotionally disturbed children 6 years ago. The Home, therefore, began recruiting foster families and small group homes. At present, the Study Home is serving 65 children: 15 in the residential center, 18 in foster family homes, 16 in small group homes, and 16 in the center's day-care program. The children in the day-care program, as well as some of the children in foster

families or group homes who need special educational assistance, attend the school operated by the agency at the residential center.

Through individual and group therapy programs for parents, we help parents maintain the strength to allow the children to remain in our program. We are now exploring the use of family diagnosis and therapy techniques. Mrs. Fine's article lends weight to the plea for exploration of new approaches. It is indeed gratifying to learn about what one agency is doing to revitalize a fundamental approach to the child who needs reconstructive experience.

Zeannette W. Lynch
Grace Spillane
*Children's Study Home
Springfield, Mass.*

WRIGHT: Do we care enough?

The introduction to Mattie K. Wright's lucid article, "Comprehensive Services for Adolescent Unwed Mothers," makes the old indictment that agencies fail to reach girls from the lower socioeconomic group. [CHILDREN, September-October 1966.] Granted, existing services are inadequate, chiefly because of lack of money, manpower, and a sense of mission. But for years, The Salvation Army has been reaching some of these girls. A study by Dr. Deborah Shapiro in three Salvation Army homes reported that the girls were "fairly heavily concentrated" in what is "upper lower class": 67 percent were white; 33 percent, Negro. Of the white girls, about one-third were from middle class families; two-thirds, from lower class. All but four Negro girls were from lower class families.

In Cleveland, for example, The Salvation Army is making a concerted effort through a day center with casework, group work, educational classes, medical care, vocational guidance, psychiatric consultation to take services to the people in their homes in the neighborhood. True this is just a "drop in the bucket" in relation to the needs, but it is *something*!

I hope Mrs. Wright's timely article will be read, studied, and acted upon by agency staffs and boards. It is studded with penetrating ideas which should move all of us to do more than we are now doing to reach more unmarried mothers, especially adolescents from low-income families.

I would like to underscore five ideas

in the article: (1) *Concern* prompted the project; (2) the project is carried out through *collaboration* of health, education, welfare, and recreational services; (3) the project is located *close* to the people in need; (4) *criteria* are established for admission; (5) the demonstration project is being *continued* by a tie-in with local agencies.

At least three questions trouble me: (1) Do we need more research so that we can find more ways to give more help to girls like those in the 2S2 not accepted by the project? (2) Can we do more with unmarried fathers? (3) After the grants run out, what then?

Major Mary E. Verner
*Women's Social Service Secretary
The Salvation Army Eastern Territory
New York City*

MOSS: Tunnel vision

The article by Sidney Z. Moss, "How Children Feel About Being Placed Away From Home" [CHILDREN, July-August 1966], is valid in pointing out the necessity for helping children cope with their feelings about separation from their families if they are to use a placement experience in ways that will benefit them.

However, the article remains rooted to this factor, only one among many other important factors to which all child welfare workers must be sensitive. This too readily induces the type of tunnel vision that seriously limits a caseworker's helpfulness.

Many, probably most, of the children coming to care these days, whether to family or to a group care service, come as a result of complex family problems. Most of these children have previously been faced with separation, rejection, deprivation, and other traumatic experiences. Yet in his article, Mr. Moss states: "... when a child is placed in an institution, he faces two difficult adjustments: mastery of the separation trauma; and adaptation to the institution."

It is almost as though Mr. Moss believes that the children's first experience of crisis is the placement itself and that the goal of the caseworker is merely to help them adapt to a new environment. Elsewhere, Robert Lindner has aptly labeled this point of view as the "myth of adjustment." In point of fact, children usually arrive in placement with internalized feelings stem-

ming from their past experiences, and increasingly their functioning in regard to these experiences is a significant factor behind their referral for placement. We must not have a stereotyped response.

For example, a teenage daughter of divorced parents was recently referred to our agency. The father had disappeared. The mother was trying to support her family alone. This child harbors death wishes for her mother and is defiant and unmanageable. Since the mother and daughter cannot resolve the difficulties in their relationship while they are so close to each other, the mother is now seeking placement as a means of providing the girl with the help she needs.

This child has already experienced the trauma of separation—from her father at age 11. In all likelihood this loss, having come at a critical time in her emotional development, is a salient factor in the emotional separation both mother and child are now experiencing. Which of the separation traumas would Mr. Moss elect for this girl to master first? That with father, with mother, or that which comes about again at the time of placement? There are several, and they need to be differentiated in the caseworker's understanding if the child is to be helped.

Elizabeth Lawder has pointed out in her article, "Can Long-time Foster Care Be Unfrozen?" [Child Welfare, April 1961], that there is no panacea to the problems of children in foster care today, that much of what inhibits the creative, purposeful, and productive use of placement as a treatment tool is the "rescue fantasy" phenomenon of professionals in the child welfare field, and that the growing body of knowledge about childhood could expand our understanding, influence practice, and ultimately lead to a differential concept of foster care.

Mr. Moss deals exhaustively with a part and, in so doing, lends weight to the "panacea approach." Unavoidably, the price paid for simple solutions to complex situations is poor service, for to deal with a part as though it were the whole is considerably less than the competent professional endeavor that is mandatory in seeking solutions to the problems of today's children.

F. Herbert Barnes
*Executive Director, Carson Valley
School, Flouertown, Pa.*

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children

A Foster Grandparent Program

Conflicts in Behavioral Research

Home Therapy for the Retarded

Youth Services in England



children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Reaching out for each other's love, this foster grandchild and her foster grandmother meet every day to help each other, each in her own way. Through the program described in our lead article, older men and women and neglected, disturbed young children are brought together as foster grandparents and foster children to the good of both. (See page 46.)

children

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● They wait at the gate to greet their foster grandparents. Eager, impatient children wait for equally eager foster grandparents who will take them out of the group-care unit of the county child welfare agency to the privacy of a vacant sitting room, office, niche in the hall, or spot under a shade tree on the institution's grounds.

All are children being cared for by the Medical and Emotional Treatment Service Unit of the Summit County (Ohio) Child Welfare Board, known by the staff as the METS. Most of them are of preschool age, and most of them have physical, mental, or emotional handicaps, or a combination of these problems. All are under the county's care as dependent and neglected children.

The foster grandparents come to the children for 4 hours a day through the Foster Grandparents Project, a demonstration project to give employment to needy persons who are over the age of 60, sponsored by the Office of Economic Opportunity (OEO) and the Administration on Aging of the U.S. Department of Health, Education, and Welfare. The chief interest of the Summit County Child Welfare Board in participating in the project, however, has been in tapping the potential of foster grandparents as treatment agents in its social casework efforts to help the children to a happier life.

Through its METS unit, the Summit County Child Welfare Board provides temporary group care for some young children who must be removed from their homes for their protection—and sometimes their very survival—and for whom no other arrangement is immediately available. Many children arrive at the agency with such aggravated behavioral problems that even the most experienced and capable foster parents could not cope with them. Even some very young children seem so damaged by their experiences that they need the kinds of control that can be provided only in group living before they can form the kinds of relationships with other human beings that are prerequisite to a successful foster home experience.

Like most child-care agencies, however, our agency has realized that its child-care workers could not give individual children enough attention to provide them with the necessary ego-building experiences. Such children, we felt, needed the kind of loving, personal attention that a foster grandparent might be able to give them.

Our agency was one of the first 21 agencies chosen by the Administration on Aging to participate in the Foster Grandparents Project. Planning took

**FOSTER
GRANDPARENTS
FOR**

**emotionally
disturbed
children**

RUTH JOHNSTON

place in 1965. It was agreed then that each participating agency would adapt its program to the needs of the children under its care within the framework of policies established by the Administration on Aging and OEO. The agencies would choose the grandparents, train them for their work, and assign them to specific children.

The staff for the Summit County Foster Grandparents Project consists of a part-time director from the agency's social service staff, a part-time supervisor hired especially for this position, and a part-time consultant and a full-time field supervisor from the agency's institutional child-care staff. In addition, a five-member advisory committee, representing senior citizens groups, labor unions, the Summit County Child Welfare Board, and the local community action council, meets together regularly to review the program's policies.

Selection and orientation

The actual hiring of grandparents began in January 1966. Ten grandparents were accepted at that time from 75 applicants. Later, the agency employed two other groups of foster grandparents—10 in each group. Of the 30 foster grandparents employed, 23 are still in the project—18 grandmothers and 5 grandfathers.

For acceptance to the program, the applicants had to meet the OEO criteria of having no more than

\$1,800 per year income (since lowered to \$1,500) and of being over 60 years of age. They also had to have their physician's approval and had to be able to hear and see well, to move around easily, to pick up small children, to climb stairs, to sit on the floor, and to play games.

Other criteria called for the subjective judgments of agency staff members made on the basis of personal interviews and of study of the foster grandparents' written applications: functional literacy; reasonably good grooming; pleasant appearance; ability to listen and ability to express meaning; and some indication of having had enjoyable experiences with children, their own or other people's.

In our selection process, we sought evidence of satisfactory life experiences; adequate adjustment to age and financial status; an interest in people, especially children; a wish to be of service to someone; and an ability to understand and accept the agency's policies. We tried to find clues to these qualities during the application process and through observation of the applicants as they were shown through the METS unit. One crucial test was the "touch test"—a literal reaching out to children followed by a spontaneous and positive response from the children.

Before the orientation program began, we had wondered whether older people not used to an academic approach would be able to accept and benefit from an orientation program. We had wondered how approachable they would be in respect to the staff

and one another and how adaptable they would be to the routine and policies of the agency. We were pleasantly surprised to find that the foster grandparents immediately saw themselves as a "group" and began at once to participate in the discussions. They seemed to have the wisdom that comes with age and genuine interest in the project.

The orientation began with an overall description of the agency, its plant, staff plan, and major policies regarding child care. But, the chief focus was on helping the foster grandparents understand the children and how to work with them. When we outlined the ways in which children normally develop, we found the foster grandparents were interested from two standpoints: (1) As a new way of looking at child-rearing practices, since most of them had never before considered child rearing from a theoretical point of view; and (2) as an opportunity to tell of their experiences with their own children and grandchildren.

After discussing theory, we focused our attention on the particular children with whom the grandparents would be working. Again we were pleasantly surprised at the general openmindedness and flexibility shown in these discussions. However, we found out later that all the foster grandparents had not understood all of what was said and were not actually prepared for the situations they would face. But, in spite of some difficulties with the children, they stood pat in their determination to help the children assigned to them.

We tried to help the foster grandparents understand that these children would not be like their own grandchildren and that as foster grandparents they would have different obligations and responsibilities than as grandparents. We told them that a major goal of the project was to meet each child's needs and help him solve his problems.

During the orientation week, we discerned many kinds of strength in the foster grandparents—sin-

cerity, security, self-esteem, flexibility, warmth, and stamina—that we hoped would be passed on to our children. We also found weaknesses in these areas. However, by appraising each individual, we attempted to match grandparent and child so that their strengths and weaknesses would complement one another's. The goal was to provide the child with a person to whom he could relate and in whom he would see the qualities he needed most.

By the end of the orientation week, everybody was eagerly anticipating the climax—the assignment of particular children to particular grandparents. We arrived at these assignments on the basis of information received from the agency's child-care workers and the children's social workers. While these workers were usually in general agreement about the child's needs, the child-care workers tended to emphasize behavioral problems and the social workers to emphasize inner conflicts. Where it seemed necessary, we had conferences with the workers on particular children before coming to a decision. In all assignments, the child's needs were given first priority. No consideration was given to race or age of grandparents or child.

Agency team members

The first foster grandparents received their assignments on January 28, 1966. On that day, the foster grandparents, all of whom had been introduced to all the children previously, were literally sitting on the edge of their chairs in their eagerness to find out which ones they would get. Without exception they accepted the children selected for them. Subsequently, either the director or supervisor talked with the grandparent, giving him information about his particular child that would help him in working with the child. The grandparent was frankly told about the child's present problems and what the agency's long-term goal for him was, given suggestions for dealing with the child, and encouraged to do "what comes naturally" within the framework of the agency's rules and the child's special needs.

Each foster grandparent and child were assigned a place where they could be alone together and were supplied with a bag full of toys selected for that particular child and used by him only when he was with his foster grandparent.

The foster grandparents showed a surprising ability to understand and accept the basic policies of the agency with regard to the development of children and to help us implement them. In fact,

Ruth Johnston has been since 1965 administrative supervisor, Summit County (Ohio) Child Welfare Board, where she is also director of the Foster Grandparents Project described here. Previously she was for 13 years director of child welfare in the Arkansas Department of Public Welfare. A graduate of the Columbia University School of Social Work, she has also worked in child welfare in North Carolina.



one of our staff members has used the term "intuitive casework" to describe what some of the foster grandparents have done.

We feel, and let the grandparents know we do, that they are a part of an agency team caring for children. They keep a record of their work with the children and are encouraged to report both the good days and bad days and to express their own thoughts about the child, his problems, and his progress. These records are shared with the child-care and social work staffs. The entire staff has been pleased to see how pertinent they are.

Warm relationships between the foster grandparents and their assigned children began developing immediately, and the grandparents soon learned at first hand about the children's problems.

One grandmother wrote after a short time:

Johnny was so glad to see me. They told me he could hardly wait until I came. We got our toys and went to our room. I noticed he was nervous and shy. All at once he began to open up to me and tell me how his mommy had come and brought him some toys, and he asked me to please help him grow up so he could whip his daddy for beating up his mommy. It broke my heart to see him in this attitude. I think parents' troubles shouldn't be pushed on the child, especially at this age. Johnny is very smart and understands more than most children his age.

This grandmother has said that Johnny's show of feeling came as a shock to her even though she had been warned. However, a warm relationship has developed between them.

In this early period a foster grandfather wrote of a very disturbed little boy:

He is to me the greatest because he is my grandson. He is not what I would call a bad, bad boy. Sometimes he is nice as he can be, otherwise is real mean, but I hope to help to make a good boy out of him. There are times I think I see a big change. I hope every day I can find some way to cope with him.

The grandfather has found a way to cope, and the change in the child is almost unbelievable.

One woman was assigned a little girl who was so withdrawn that she went for days without speaking. After a while this foster grandmother wrote:

I have noticed a change in her personal pride. Now she will ask me to comb her hair, give her a bath, put her in a dress instead of pants. These are things she did not even notice when I got her, and to me this is a marked improvement, for as long as you can keep a child's personal pride up and keep it feeling someone else cares you have a chance of their trying to build a life.

In general, the foster grandparents have been most willing to share their impressions with other staff members. However, as they get to know a child they

tend to become increasingly protective of him and have to be reminded from time to time that their job is not to protect the child from criticism, but to work with everyone else toward helping him overcome his problems.

Some foster grandparents have been remarkably acute in their observations. One recorded:

Every day I understand him better and treat him as an individual. He seems to be searching for something he can't quite find, and to be inwardly at war with himself, which makes him resentful and rebellious.

Some byproducts

After nearly a year we are able to appreciate the program from the standpoint of the agency, the social work staff, the child-care staff, the foster grandparents, and of course the children.

Agency benefits. In addition to what the program has done for our children, it has resulted in increased community good will toward the agency. The 30 foster grandparents and 5 advisory committee members who have taken the orientation course and the community agencies that have referred prospective foster grandparents to the agency now have a better understanding of the agency and its program. And the agency has been called to the attention of the public at large through favorable news and magazine stories focused on the opportunity it has given older people to work with children.

Casework benefits. The agency's social workers probably had both the greatest hope and the most misgivings of all the staff members about the Foster Grandparents Project. They realized that the children would benefit from a one-to-one relationship that the child-care workers could not provide. They recognized that one or two visits a week from a caseworker was not enough to sustain a very young, disturbed child. However, their training and experience had taught them the value of skilled casework based on investigation, diagnosis and treatment, and they wondered how foster grandparents with no professional education could fit into a casework plan.

The social workers also wondered how, with the restrictions on age and income set by the Office of Economic Opportunity, foster grandparents could be found who were not too physically, culturally, and educationally limited to be able to give the children what they needed. They also wondered whether the children would be faced with conflicts in loyalty between caseworkers and foster grandparents or be-

tween foster grandparents and the child's own parents and relatives. They wondered whether the foster grandparents would have enough understanding and stamina to bear up under the child's expressions of hostility or whether they would get enough satisfaction out of the job themselves to be able to give anything of value to the child.

Almost without exception, the social workers' fears have been laid to rest and their hopes fulfilled. Moreover, they have often found information gained from the grandparents useful in furthering their own understanding of the children in their caseloads. For example, a grandparent wrote of a child:

We went for a walk today and she opened up a bit by talking of her mother, whom she mentions quite often, but more than her mother she speaks of her father. Sally asked me why doesn't her daddy get well. I did not know what or how to answer her but I tried to make her feel better. . . .

Sally had not previously revealed her deep concern about her father. Learning of it through the foster grandparent, the social worker could help the little girl deal with it.

During the past year, among the children who were assigned foster grandparents, nine have been returned to their own homes and nine have been placed in foster family homes. While the foster grandparents cannot be given the entire credit for the emotional progress that enabled these children to go into a family setting, in each case a foster grandparent made a definite contribution toward it. The social workers helped the child use the relationship with his foster grandparent to find the strength for these moves.

While the grandparents have felt sad at the loss of the children, in each case they gave them real support in moving on. One foster grandmother wrote to a once extremely withdrawn child:

This is from your dear grandmama, and I must say that I have enjoyed you so very much since I have had you in my care, and I did my best to bring you up to here with a secret prayer. Wherever you go, or wherever you be, I pray that the good Lord will be there.

Another foster grandmother who had helped a very aggressive child establish control recorded:

Bill has been informed he is going to a foster home where he will have a mommy and daddy. He is strong willed sometimes, slow to obey, but, if let alone, he will change his attitude. I am very happy that he has a mother and daddy plus a good home because that is what every child needs to develop a strong character and become a good citizen. I really am reluctant to give him up, but it is for a better way to develop finer character. I keep telling him he is leaving his foster grandmother for a real foster mother plus a home of his own and so much else to make him feel free and happy.

Some of the social workers have reported that the children in their caseloads are more approachable since they have had foster grandparents, that they talk more to the social workers, listen better, are more able to bear the separation from their parents, and generally have a better feeling about people, particularly the adults in their lives. One grandparent wrote a little boy who 3 months earlier had had great difficulties in personal relationships:

It has been a pleasure working with Dan, also a real challenge at times, but it has been rewarding just to see him grow in size, disposition, and temperament. He has changed from the sulky, disobedient little fellow I met on May 3. I feel my time and effort have been well spent.

Child-care benefits. The foster grandparent program has meant that some children are out of the child-care unit for 4 hours a day, thus giving the child-care workers more time to spend with the children who do not have foster grandparents. As a result, the children in group care are happier, more relaxed, and more controllable.

The houseparents tell us that having a foster grandparent is a "status symbol" among the children. They also report that the children who have foster grandparents play better, eat better, sleep better, and look better than the other children.

Children in METS who do not have grandparents are those who are in temporary care, who are too young, or whose particular needs could not be met by any foster grandparent who is available for assignment at the time.

Some minor difficulties have occurred in the METS unit since the initiation of the foster grandparent program. Child-care workers and foster grandparents sometimes meet head on with conflicting ideas, often involving housekeeping problems and occasionally resulting in bruised feelings. However, since foster grandparents and child-care staff alike have genuine concern for the welfare of the children, none of these minor difficulties have amounted to anything that poses any real problem. There is generally a friendly, satisfying give and take between foster grandparent and houseparent. If any real difficulty should arise between them, however, the supervisor of the child-care staff would be responsible for dealing with it.

Grandparent benefits. The foster grandparent themselves all seem to enjoy a feeling of being of use. One foster grandfather said recently that it gives him a reason for getting up in the morning.

When the foster grandparents are asked what the experience has meant to them, they nearly always

cite the progress they see in the development of the children assigned to them and their pride in their accomplishments. One grandparent reported:

Fred was very good and played good and was in an unusual good mood all morning. He did not bite or try to bite me or anyone.

In spite of being bit, hit, kicked, spit on, cursed, run away from, berated, yelled at, and disobeyed, the foster grandparents have kept perspective and have often seen the deeper meaning of the child's behavior and even the humor in it. One seriously disturbed child suddenly hit his grandmother with a knife handle and then complained because she bled. Three months later the same child accidentally kicked the grandmother while playing and was most solicitous and concerned. The foster grandmother reported both incidents, the second with pride, even though it had resulted in a black eye for her.

There has been almost no absenteeism among the foster grandparents except for illness. They have come to the agency through cold and heat and on holidays. They have gone with their children on all-day picnics, hikes in the woods, walks in the park, visits to the circus; they have gone wading with them to help them catch tadpoles; in short they have gone wherever the children have gone, without question and apparently with pleasure.

The children

The *raison d'être* of our program is, of course, the children—what they have needed, what they have received, and what they have become. For them the experience has been a positive one physically, mentally, and emotionally. We have followed Erikson's eight stages of man¹ in classifying the development that has taken place in the children during this period. Some children have made remarkable progress; others, very little. However, in every case some progress is evident.

Sense of trust. For many of our children the relationship with their foster grandparent is the first positive relationship they have had with an adult. It starts, whether the child is age 2 or 8, with having a lap to sit on and involves being cuddled and comforted. It moves on to confidence that the foster grandparent will do what he says he will do.

Before coming to us many of our children have been given little in their own homes except the bare essentials. Yet after a child's placement away from home, his parents often try to make up for their



The attention this foster grandparent is giving a sick-abled child is clearly making this little girl forget her illness.

own hurt and that of the child by bringing him gifts. To the child these seem only a superficial token of love. We try to restore the proper balance by having the foster grandparents give the children much attention and warmth but little in a material way. The foster grandparent and the child take a walk together to enjoy one another and the outdoors rather than to get an ice cream cone. However, if occasionally the grandparent combines the two purposes, we do not object.

Autonomy. Through their genuine feeling for the children, the foster grandparents have helped absolve some of the shame and doubt brought on the children by the loss of their parents.

We believe that the grandparents, using their own experience, interest, initiative, and imagination, have helped develop the children's personalities in a more personal and intimate way than could have been done by a social worker or child-care worker. They have helped children develop a feeling of worth by offering them warm affection, and this affection has deepened as the children have begun to return it. They have demonstrated their sense of the child's worth by doing things for him—bathing, dressing, combing hair, tying shoes, pulling up socks, putting on mittens and cap. Through words, expressions, and gestures, they have shown appreciation of the child himself and their pleasure in the way he looks, behaves, and

achieves. With very young children, they have done this unconsciously through simple games such as "Show me your nose."

The fact that the foster grandparent "belongs" to the child adds to the child's sense of worth. Children have shown their need and their appreciation of this by being very possessive of their grandparents and very jealous of their attention.

Initiative. The grandparent not only encourages the use of the creative toys provided for the child; he also participates in imaginative play with them, thus helping the child learn to use initiative and imagination. Showing his appreciation of the child's creative efforts, he encourages the child to experiment not only with what he can do with his own mind and body but also with how he can control outside things.

Many of our children have insufficient ability to express themselves in words. Not having been encouraged to talk in their own homes, they tend to act out rather than talk out their feelings. Because of this we have urged the foster grandparents to read aloud to the children, to tell them stories, and above all to talk to them and to encourage them to respond. As a result, many of the children have learned to talk not only about the things they see around them but also about their thoughts and feelings.

Industry. We have encouraged the foster grandparents not only to do things for the children but also to expect the children to do things for them and eventually for other adults and other children. Children willingly run errands for grandparents, help them pick up toys, and do other things because "Grandmother asks you to," and they seem to derive a sense of satisfaction from it.

Foster grandparents have also taught children how to greet people, how to eat properly, and how to take care of themselves and their clothing. Many of our children have had no previous opportunity to learn about such social amenities. Feeling comfortable in these areas increases the child's self-assurance, thus releasing energy for further growth.

Foster grandparents have also helped some children prepare to enter school. By showing their appreciation of the children's efforts they have made learning easier for the children.

One determined foster grandparent helped a physically handicapped little girl who had spent most of her time in a wheelchair progress first to a walker and then to crutches. There were numerous clashes of will, sometimes ending in a draw, but most often in the grandparent's maintaining control and in turning the experience into a positive one for the child.

Sense of identity. The foster grandparents have helped children establish a sense of identity by each transmitting to his child his feeling that the child is special, through helping him know what he can do, and through helping him accept controls. Many of our children before coming to us were controlled too harshly or not at all. The foster grandparents are making a great contribution in helping the children respect both their own rights and the rights of others by establishing a benign control.

The foster grandparents have also helped children learn to share—for example, to take turns on a tricycle. The grandparent is obviously proud when his particular child awaits his turn, especially when the child thinks of something interesting to do while waiting.

The grandparents have also helped the children become conscious of the world around them. We have encouraged them to take their children walking and to call attention to the sunlight, fresh air, green grass, birds, insects, and pebbles. Last spring METS was ablaze with dandelions in peanut butter glasses. Last summer it housed large collections of tadpoles, bugs, and pebbles. Last fall, red and yellow leaves lined the walls.

We believe that the very fact of being taken out of the group physically for a period of quiet and relaxation with only one other person has been of great benefit to the child. It has not only allowed him the satisfaction of a one-to-one relationship but has also given him an opportunity to become acquainted with himself and to learn about his own areas of strength and limitation by experimenting on an accepting adult.

Obviously, we feel that this experiment has been a success.

¹ Erikson, Erik H.: *Childhood and society*. W. W. Norton & Co., New York. 1950.

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CONFLICTING VALUES AFFECTING BEHAVIORAL RESEARCH WITH CHILDREN

M. BREWSTER SMITH

What limits, if any, should be set on research into children's behavior? Who should set these limits? These, and other questions related to them, are being asked these days by many people in and out of research—parents and law-makers included.

Only recently, when research on behavior was a marginal activity of a few college professors and their graduate students, carried out with little financial support and that support received mainly from private donors and foundations, such questions hardly arose. From the professor's standpoint, the responsibility for decisions about the nature of the research was solely his—a matter of academic freedom and privilege within the framework of formal or informal codes of professional ethics. Nobody was likely to challenge him: The whole enterprise of research in the behavioral sciences was unimportant and inconspicuous, and public funds were not involved.

Today, however, the behavioral scientist has to pay the penalty for success. Behavioral research is no longer inconspicuous: Even though it is not as affluent as the physical sciences, it is now big business. And since most of its financial support now comes from the Federal Government, its errors of judgment as well as its successful results now attract political attention. Public concern with the methods that scientists use in studying other people is of course

warranted on grounds quite apart from the basis of funding.

For perspective on the special problems of controls on research with children, we had best begin with a brief look at the anxieties and misgivings about the political and ethical aspects of the behavioral sciences that figure prominently in the current climate of discussion.

Many people, including U.S. Congressmen, are worried about many loosely related issues. Do personality questionnaires violate the citizen's right to privacy when used in government personnel procedures or in research? ¹ Is it ever permissible for experimenters to deceive the subjects of their experiments, as some types of investigation seem to require? ² If deception is used, how can the "informed consent" of subjects be obtained? ³ Do the potentialities for computer retrieval of data collected for administrative purposes (tax returns, census files, and the like) threaten the privacy and perhaps even the liberty of the individual citizen? What of Government-sponsored research in foreign countries—how can the sensitivities of the citizens of other countries, the interests of the U.S. Government, and the needs of the social sciences for comparative data all be taken into account? ⁴ How can the Government and the public be assured they are getting their money's worth out of social and behavioral science? Is adequate support available for the study of socially important

problems?⁵ All these questions and many others have found their way into the legislative hopper. Several congressional committees have held hearings that bear upon them. Suddenly, the social and behavioral sciences are politically visible.

Issues concerning children

Each of these issues has its counterpart for research on the behavior of children, though issues concerned with studies of children in foreign countries have not yet received much attention. But the issues look and are different when children are involved.

Personality questionnaires and the right to privacy. When children are questioned for research purposes, the privacy and sensitivity of parents have to be considered in addition to the possible effects of the questioning on the child. Some kinds of questions—those about sexual attitudes, knowledge, and practices, for example—are likely to be regarded as intrinsically inappropriate in questionnaires for use with children; questions about child-rearing practices, on the other hand, may be seen as invading the parents' right to privacy and perhaps even as undermining parent-child relations.

Parents who have little understanding of the methods or objectives or value of behavioral research have objected to their children's being asked about their parents' education and other indicators of socioeconomic status—seemingly incidental information that is often essential in a research project! Very likely only a few parents would be disturbed by the kinds of questions a responsible investigator would find necessary and proper to ask, but their objections have to be taken seriously, not dismissed impatiently as "crackpot." The narrowest interpretation of what is permissible would put many important problems beyond the range of possible research. The most lenient would affront many citizens.

Deception. In this regard, the issues concerning children shape up differently from those concerning deception with college students and adults. In a typical case, the problem under study requires the subjects to undergo a standard sequence of successes and failures on an experimental task. To produce this standard sequence, the subjects are provided with believable false reports about their performances of the task, according to the requirements of the experimental design.

Generally, investigators working with adults or college students attempt to meet the ethical problem

in such deception by carefully explaining the reason for the deception to each subject after the experiment is over. When the subjects are students in psychology courses, such a "debriefing" procedure usually makes sense (though it may not balance the harm done to the students by conveying the idea that a manipulative approach to people is acceptable). When "debriefing" is carried out scrupulously, the participant may learn something relevant to his studies, both about psychological research and about his own reactions.

In research with young children, however, no one can argue for "debriefing" as an adequate solution to the ethical problem of deception. A full explanation of procedures to the young child is seldom desirable or possible. In the example that we have been considering, the usual scrupulous practice would be to so contrive matters that by the end of the session every child would leave with a solid experience of success.

Yet such a solution leaves one uneasy. The experimenter who knows that he must subsequently explain to his adult subjects just how he has deceived them may be likely to exercise self-restraint in his procedures. The experimenter with children is under no obligation to explain himself to his subjects, and if he is not required to justify his procedures to others, everything hinges on his private judgment. Can the experimenter's unavoidably self-interested judgment of what is best for the child be trusted?

Consent. The difficult but crucial issue of when the participant in research may be regarded as having given his informed consent appears in a different guise in respect to research with children. Legally only parents can consent on behalf of children. But when is parental consent "informed"? How much do parents have to know about a particular research project before their consent may be so regarded? When, if at all, may the responsible authorities in schools and other social agencies give consent *in loco parentis*? When, if at all, may implicit consent be assumed? Any call for a rigid enforcement of a requirement for explicit parental consent presents serious obstacles to research studies that hinge on obtaining data from a representative sample of children. This is because, in ways that affect their children, the parents who neglect to return consent forms may differ from those who do return them. A narrow interpretation of the consent issue could very seriously hamper behavioral research with children.

Uses of information. Whether information col-

lected for administrative purposes that can be retrieved and collated by a high-speed computer for other purposes presents risks to the privacy and liberty of adults is still a matter for conjecture, since such data banks are not yet generally available. However, the cumulative school records of children's psychological tests are already with us and may do real harm.

Useful as ability tests undoubtedly are, they are clearly a mixed blessing.^{6, 7} The low test scores of a child who gets off to a poor start may exclude him from opportunities to improve his position. Teachers who rely on the predictive power of a poor score help confirm the prediction. On the other hand, without test results, social stereotyping might play a larger part than it does in deciding a child's educational future. Much careful thought and further research are needed to find ways of using ability tests so as to maximize each child's educational opportunities instead of accentuating existing inequalities of opportunity. Because the testing technology is a product of scientific psychology, problems concerned with the administrative use of tests naturally get entangled with the logically distinct problems of their research uses. It is important to keep the issues separate.

Information collected from children for research should never be used to their disadvantage. When the nature of the research permits data to be collected and stored anonymously, the interests of the individual child can be readily protected. When, on the other hand, identification of individual persons is essential to the research—as in “longitudinal” studies that follow the same persons over a period of time—elaborate precautions are essential to safeguard confidentiality. In such research, protecting the anonymity of the persons studied is an absolute about which there can be no compromise.

Competing values

As we explore these issues, it is easy to become preoccupied with the dangers of using children as subjects of behavioral research and the safeguards necessary to protect them at the expense of appreciating the actual and potential contributions of behavioral research to child welfare. The cumulative findings of research on child development are just beginning to break the cyclical fashions in child-rearing advice.⁸ In this country we are just launching a host of new and expensive programs in the schools based on extrapolations from current knowl-

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edge about behavior that urgently require monitoring and rigorous evaluation through research. Now is not the time to stifle behavioral research with severe restrictions.

In its own interest, the public needs to make some accommodations to the requirements of research. Behavioral scientists and the agencies that support their work should be actively involved in educating the public and its representatives in Government to the characteristics and value of such research.

The beginning of wisdom in this regard, it seems to me, is to recognize that we must come to terms with competing values. Humanitarian values require that we never harm the individual child and always strive to advance child welfare. Libertarian values require us to respect the integrity and privacy of the child and his parents. Scientific values prescribe the extension of knowledge for its own sake, usually with the faith that in the long run knowledge contributes to humanitarian ends. Legal values require us to respect the status of minors and the rights and obligations of parents, though legal rights in relation to behavioral research are still in the process of clarification.³ Often these different frames of evaluation point to the same conclusion. The cases in which they do are the simple ones that pose no serious practical or ethical problem. But often they conflict with one another. For example, the child's privacy and perhaps his integrity are violated for the sake of advancing knowledge of a topic that is theoretically and humanly important when, in a study of how moral character develops, he is tempted to cheat and whether he does so or not is surreptitiously observed. In such instances, we need principles and mechanisms for adjudication.

Both principles and mechanisms become indispensable once we grant that decision on these conflicts in values can no longer be left to the unaided conscience of the individual investigator. Now that behavioral science has grown so important that it captures pub-

lie attention, forces are clearly such that decision will not be left to the individual investigator. Nor should it be. He is likely to be a biased judge, one who will set a higher priority on scientific values than nonscientists are likely to do. He wants so much to conduct research and to advance knowledge that, being human, he may underestimate or rationalize away the costs and risks to his subjects. At any rate, he is open to the legitimate suspicion of being vulnerable to bias. Anyone who has been privy to discussions among tough-minded behavioral scientists about the "trade off" between ethical risks and potential scientific gain will have no doubt that this bias exists.

Codes of ethics

Further codification of ethical principles by the scientific disciplines concerned to help guide decision in the difficult cases is a much needed first step. Existing codes of ethics provide a good start but they stop short of some of the harder issues before us. Thus, the code adopted in 1959 by the American Psychological Association⁹ provides for the confidentiality of research materials and calls upon the psychologist to show "sensible regard for the social codes and moral expectations of the community in which he works. . . ." In what is probably the critical principle, it states:

Only when a problem is significant and can be investigated in no other way is the psychologist justified in giving misinformation to research subjects or exposing research subjects to physical or emotional stress.

a. When the possibility of serious aftereffects exists, research is conducted only when the subjects or their responsible agents are fully informed of this possibility and volunteer nevertheless.

b. The psychologist seriously considers the possible harmful aftereffects and removes them as soon as permitted by the design of the experiment. . . . [Principle 16. *Harmful aftereffects.*]

Such a code of principles typically contains some absolutes. (Provision *a* above approaches an absolute requirement for voluntary consent, though the decision about when a "possibility of serious aftereffects exists" remains judgmental.) More of the principles will point to strongly desirable or highly undesirable practices that are nevertheless open to some kind of negotiation.

I would like to see some nearly absolute principles added that, I think, are essential to maintaining a relationship of trust between researcher and human subject, a relationship that is a prerequisite to society's continued tolerance of the behavioral scientist.

Under very few circumstances is an investigator justified in violating a pledge of confidentiality given to a research subject, even though the interests of the subject are fully protected. The frequency with which hidden devices are used to identify supposedly anonymous questionnaires is deplorable. I would also like assurance that when an investigator *has* employed deception and subsequently explains his action to his subjects in a "debriefing" session, he presents the literal truth—and does not, as sometimes has been the case, use the session for further experimental manipulation.

However, in general, I would prefer to keep the absolutes to a minimum and would open even the few absolutes proposed to debate and to legitimate exceptions, under safeguards of a sort to be discussed shortly. Thus, I can imagine a research situation in which the covert identification of questionnaires might be an essential and justifiable method for checking on the effects of lack of anonymity on questionnaire responses.

The inherent limitation in ethical codes is the leeway they leave for human judgment and for balancing competing values. Without such leeway, any code would be unworkable; with it, the code is open to evasion. Application of ethical principles to real cases is literally a problem in casuistry and is vulnerable to the abuses that gave casuistry a bad name. In the principle I have quoted, what determines "when a problem is significant"? How much unsuccessful search do we require of an investigator before we allow him to decide that the problem "can be investigated in *no* other way"? How big a probability is a "possibility" of serious aftereffect, and how much does the experimenter have to hurt people for it to be "serious"? And who is to decide all this?

I am not criticizing the ambiguous wording of the principle. Insofar as there is no objective, common measure by which competing values can be "traded off," the fallibility of human judgment cannot be eliminated from decisions about the ethics of research. The question is whose judgment should it be and under what safeguards. What we need, therefore, are mechanisms of responsible "due process."

A due-process mechanism

At present, universities throughout the country are having their initial experience with one type of such a due-process mechanism. Through regulations promulgated in February and July 1966, the Surgeon General of the U.S. Public Health Service requires

every institution receiving a USPHS grant to develop principles and procedures governing the use of human subjects in research. A crucial feature of these requirements is a review of the judgment of each principal investigator or program director by a multidisciplinary committee of his institutional associates. Since the procedures became operative only on November 1, 1966, it is too early to report the experience that universities have had in administering these controls. After an era of laissez-faire, an attitude which can no longer be justified, I can safely predict that loud complaints from academic investigators will be heard for some time. Nonetheless, with only slightly less assurance, I also predict that a decentralized system of institutional review on the USPHS model will become the pattern for the social control of federally financed research on human subjects, including children. I think it is a desirable pattern, for all the nuisance it is creating.

What will this decentralized system accomplish?

1. It will assure the public and its representatives that the welfare of human subjects is protected by adequate safeguards. The acceptability of an investigator's procedures will be reviewed by others and will be justified to them. The requirement that the review committee be interdisciplinary promotes the development of common ethical standards across disciplines and professions and is likely to have a corrective influence on disciplines or subdisciplines that have become habituated to dubious practices.

2. Because the investigator's possible bias in regard to the ethical acceptability of research procedures is checked by making the judgment a matter of shared public responsibility, it will for the most part obviate the need for rigid and absolute rules and allow flexible judgment that takes the particulars of a research situation into account. The same considerations by which a jury system is a proper device for administering justice "beyond reasonable doubt" make a system of collegial review appropriate to the inherently judgmental issues research deals with.

3. At the cost of some initial confusion and iniquity, it will encourage creative and responsible thinking within institutions as they formulate and revise the ethical codes under which the review committees will operate. Some may wish to keep formal principles to a minimum and evolve a kind of common law from the precedents that are established in borderline cases. Others may try to spell out more fully elaborated codes. Through their scientific and professional associations, the disciplines concerned could be well advised to watch these developments

closely and to take the lead in preparing statements of principles for the institutional committees that reflect the special problems of their own areas of research.

4. It will avert the stultifying rigidity of Federal centralized administrative or statutory control over research practices.

I think the special problems of research on the behavior of children can best be dealt with in such a framework of decentralized institutional self-monitoring according to explicit principles and procedures, which can and should be modified as we learn from experience in working with them. Reviewing committees will naturally be slow to approve procedures that they are at all dubious about when the subjects of the research are young children.

A special problem

The issue that may demand the closest attention and give the greatest trouble is the one involving explicit parental consent. In regard to this problem, and to many others, behavioral research does not parallel clinical medical research¹⁰ closely enough for the medical research codes to be particularly helpful.

The relationship of physician to patient, involving as it does the highly charged issue of life and death, can when it is diverted to research objectives be perverted to an unspeakable evil (as in the Nazi death camps), unless the strictest controls protect the patient's interests. If patients are to be able to turn confidently to their physicians for help, they must know that they will not be used in medical experimentation without their knowledge and consent. In the case of minors, parental consent is the legally required equivalent of the patient's consent. (Yet matters here are not simple either: advances in pharmacology that none of us would forego depend on the use of placebos and "double-blind" designs, practices that are hard to reconcile with the principle of voluntary consent.)

In contrast to medical research, much behavioral research, with children or with adults, is concerned with far less sensitive matters. When the requirement of explicit parental consent would defeat the purpose of an otherwise important behavioral study requiring a representative sample of children *and* no reasonable person would expect the study to harm the child or insult the parents' values, an exception to the requirement seems justifiable.

The sort of responsible review of the investigator's justification of his research procedures that the

Public Health Service is now requiring makes it possible to consider such exceptions on their merits. Review groups will have to develop their own guidelines for deciding when the explicit consent of a parent or guardian should be obligatory, when parents should be given the opportunity to consent implicitly by failing to object to an announced research plan that involves their child, and when the responsible head of an institution such as a school system or a school might appropriately consent to the research being done without consulting the parents. School authorities will of course base their decisions to give or withhold permission not only on their own judgment about what is ethical but also on the compatibility of the research with the school's educational objectives for the child. The latter judgments are more appropriately made by superintendents and principals than by investigators, review committees, or parents.

Respect for the subject

Lest I give the impression that the due-process mechanism the Public Health Service has decreed for American campuses will of itself fully allay the concern about the proprieties of research with children and other human subjects, which many social and behavioral scientists share with other citizens, I need to draw, by way of conclusion, a distinction between what is ethically permissible and what is ethically desirable. My own view is that the predominant cast of much permissible behavioral research falls short of the desirable in too often adopting a manipulative or condescending attitude toward its human subjects rather than a genuinely respectful, collaborative one.

Much public resentment toward the behavioral sciences arises, I think, from correct perception of this tendency toward manipulation. Review committees and codes of ethics will not directly improve this state of affairs because inevitably they are concerned with ruling out what is not permissible, rather than with making what is desirable prevail. If and as behavioral scientists come more characteristically to grant their subjects the respect they accord to collaborators in an enterprise they understand and accept, they should, by the same token, help create a

more favorable atmosphere for behavioral research. The styles of research that prevail may be more important than skill in public relations in creating a favorable "image" of behavioral science.

In research with children, an atmosphere of respect and care is particularly important. Improvement in what is normative practice in research in the behavioral disciplines must be the outgrowth of continued discussion in the professional societies and in the universities and of resultant changes in graduate training.

Such discussions are in process as a byproduct of the review procedures the Public Health Service is requiring of the universities. As a result of participating in them, social and behavioral scientists may come increasingly to realize that they have lost their innocence. They can no longer live in a world of simple good and evil in which their research decisions follow unambiguously from academic-scientific values. Like it or not, they are now faced with picking their way among conflicting values and resolving the conflicts as best they can. It comes to many of us as a surprise, though it should not, that the modes of resolving such conflicts are in the broadest sense inherently political.

¹ American Psychological Association: *American Psychologist*, November 1965. (Special issue on "Testing and Public Policy.")

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³ Ruebhausen, Oscar M.; Brim, Orville G., Jr.: Privacy and behavioral research. *Columbia Law Review*, November 1965.

⁴ American Psychological Association: *American Psychologist*, May 1966.

⁵ Carter, Luther J.: Social sciences: where do they fit in the politics of science? *Science*, Oct. 28, 1966.

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A TIME STUDY in a WELL-CHILD CONFERENCE

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Long waiting times in a clinic are well-known obstacles to adequate health care. When these are combined with unrealistic appointment schedules and overburdened personnel, the quality of care suffers, and both patient and staff satisfaction is impaired.

One tool for improving such a situation is a time study. This tool is not used as often as it might be because of a general feeling that an effective study is both difficult and expensive. In Berkeley, Calif., however, a simple time study has been used effectively in an uncrowded well-child conference to provide a baseline for evaluation and administrative changes.

The clinic in which the time study has been applied is jointly sponsored by the Division of Maternal and Child Health of the University of California School of Public Health and the Berkeley Department of Public Health. At the time of the study, the clinic held one 4-hour session a week and was staffed by one pediatrician, two public health nurses, and a nonprofessional receptionist from the local Neighborhood Youth Corps. In addition, a nutritionist from the School of Public Health gave demonstrations to patients in the waiting room, consulted on individual problems, and participated in staff conferences.

The clinic sees an average of 15 infants and pre-school children each session, according to the local health department records for the past year. The public health nurses, under the guidance of the pediatrician, take the major responsibility for interviewing and counseling parents. The pediatrician sees each child at scheduled intervals for a history and physical examination and is available to the nurses for con-

sultation or the evaluation of a child at any time. The final hour of each session is used for a staff conference at which each child is discussed.

This procedure results in three types of visits. A mother may bring her child for a "doctor visit," a "nursing visit," or an "immunization visit." The "doctor visit" includes the nurse's weighing and measuring of the child, a conference between the mother and the nurse, and a physical examination carried out by the pediatrician who also reviews the health history taken by the nurse. The "nursing visit" is similar except that the child is not seen by the pediatrician unless the nurse requests a consultation. Such consultations or "inspections" as they are called may be requested when the child has a skin rash or a respiratory infection, or when the child presents more obscure or complex symptoms of a health problem. The "immunization visit" is a return visit of a child to the clinic for immunization only. On these visits the nurse checks briefly to be sure that no infections exist and that the immunization has previously been ordered by the pediatrician, and administers the immunization.

Collection and analysis of data

In the time study, the time each child spent at the clinic and the activities of each member of the clinic staff were timed during four clinic sessions. Using simple forms, the receptionist recorded the times of arrival and departure of each child, and the nurses and pediatrician recorded the times they started and finished each activity, with the name of the child and the type of activity performed. This did not prove

difficult. It is estimated that the total time taken for recording was about 5 minutes per recorder for each session.

A total of 77 children were seen at the 4 timed sessions, or an average of 19 children per session, 4 children more than average.

The data were analyzed to find out how the children's time was spent in the clinic and how the clinic personnel used their time. In addition, because of the use of the waiting room for nutrition demonstrations, a study was made of normal waiting room load. The nutritionist's activities were not timed directly because it was difficult to relate them to specific patients and because they did not influence the time spent by the other clinic personnel.

In order to analyze patient time, the data sheets were examined to see how many minutes each child had spent in the clinic altogether and how many in each type of activity. Data tabulated on "doctor visits" included the time the physician spent taking the child's history and giving the physical examination, and administering an immunization; the time the nurse spent in conference with the child's mother, in immunization, and in weighing and measuring; the time spent by either nurse or physician during the same visit in an activity with a sibling or siblings of the patient; and the time the child spent waiting in the clinic when no member of his family was being attended—a figure arrived at by subtracting the time spent by staff in activities with the child and his siblings from the total time the child spent in the clinic.

For a nursing visit, the tabulations included the time the nurse spent in conference with the mother, in immunization, and in weighing and measuring, and the time the physician spent inspecting the child; the time spent by either nurse or physician with the child's siblings; and the child's waiting time. Tabulations on an immunization visit included the time spent in administering the immunization—considered to include any time used for taking the history or

discussion—the time spent in service to a sibling and the child's waiting time.

The findings

Calculations made from these tabulations produce an average physician time, nursing time, and waiting time for each type of visit. The figures showed that on the average, each child spent 51.7 minutes in the clinic, 21.9 of which the child spent waiting, exclusive of the time he waited while other children in his family were being served. (The range between children was 20 to 90 minutes in the clinic and no time to 4 minutes waiting.) The pediatrician spent an average of 7.7 minutes (with a range of from 2 to 9 minutes) on each physical examination he made, including the history taking, an average of 3.5 minutes per immunization, and 2.2 minutes per "inspection." The nurse spent an average of 13.5 minutes (with range of 4 to 40 minutes) in conference with the child's parent, 4.4 minutes on immunization (with range of 2 to 15 minutes) and 2.1 minutes weighing and measuring.

The total professional time per child spent on doctor visit was 9.1 minutes by the physician and 14 minutes by the nurse; on a nursing visit, 0.4 minutes by the pediatrician (with a range of 0 to 4 minutes) and 14.5 minutes by the nurse; on immunization visits, 6.3 minutes. The average amount of professional time per child for all types of visits was 5 minutes by the physician and 13.9 minutes by the nurse.

Use of professional time

Other calculations showed the proportion of each staff member's time in the clinic spent on various types of activities. This was achieved in two ways.

The first method was to total the amount of time recorded for each of a number of types of activities and to divide by the total available time. Clinic administration, which included setting up the clinic, cleaning up afterward, and posting health department records, was one activity. Others were immunization, weighing and measuring, nursing conference, history taking and physical examination, and inspection of children. (Recording data in children's charts was considered as part of these activities. Time not spent in these activities was recorded as "waiting." This included time spent waiting between patients and time spent in a short midmorning coffee break.

Victor Eisner, left, associate clinical professor of maternal and child health at the University of California School of Public Health, Berkeley, has for the past year directed the Franklin Well Child Conference he describes in this article. Helen M. Wallace is also professor at the school and chairman of its division of maternal and child health.



The second method of calculating the use of professional time was to multiply the average professional time for each type of visit by the total number of visits of each type in a year and divide the result by the total working time in a year. While there were some discrepancies in the results of these two methods, they were not great, probably because the study days did not represent an average for the year as a whole.

Both methods showed that a large amount of professional time was being used on activities not directly involving patient care. Method I showed that the pediatrician spent only 57 percent of his time with the patient and the rest—43 percent—in waiting; Method II, that he spent only 46.1 percent of his time with the patient.

The nurses, according to method I, were spending only 66.2 percent of their time with the patient (58.2 percent according to method II), and a surprising proportion, 16.3 percent, on setting up and cleaning up the clinic, and in waiting, 15.5 percent. In addition, 2 percent of the nurses' time was going toward keeping health department records. The 66.2 percent of the nurses' time spent with the patient consisted of 57 percent in conferences, 5.5 percent in immunization, and 3.7 percent in weighing and measuring.

The study of waiting room load was made by tabulating, for each 5 minutes of time, the number of children who entered and left the clinic, and the number of children actually being seen by the nurses and pediatrician. The total numbers of patients for each 5-minute time interval were divided by the number of sessions to obtain an average number. The results showed a fairly constant waiting-room load from 9 a.m. to nearly 11 a.m. of one to four patients.

Significance of study

It proved to be relatively easy for the investigators to obtain the cooperation of clinic personnel for this study. Cooperation was solicited in discussions of the purpose of the study at clinic staff conferences during the month before its initiation. Since the purpose of the study was to obtain a baseline for evaluation of the clinic, with the possibility that administrative changes might ensue, a discussion of the types of changes that might result also took place at these sessions during which it was pointed out that the study was not being made because of dissatisfaction with anyone's work.

In spite of these prestudy discussions, two record-



A family in the waiting room of a well-child conference.

ing difficulties arose at the start of the project due to misunderstanding on the part of staff members. The clinic receptionist neglected to record times of the children's arrival and departure during one session, and on the first study day one nurse failed to separate weighing and measuring time from nursing conference time. These difficulties necessitated the extension of the study from the three sessions planned to four sessions and the discarding of the defective data.

The analysis of this study required approximately 4 hours of the investigator's time and the use of a desk calculator. We required less than a full hour, divided into several sessions, to explain the study to participating staff members and to instruct them in the use of the data sheets.

Although the study was planned only to provide baseline data, it elicited certain facts that are of significance to the field of public health practice. For example, the fact that each child and his parent spend, on an average, 21 minutes of their time in the clinic waiting suggests that an opportunity exists for the extension of health education to other areas besides nutrition.

The use of the nurses' time, as found by the time

study, deserves comment. When 16.3 percent of the time of two nurses is used to set up and clean up the clinic and another 3.7 percent to weigh and measure the child, a fifth of the nurses' time is expended in procedures for which professional training is not required. Such duties could be performed by trained volunteers or by trained subprofessional aides. The untrained aide who was working at the clinic as a receptionist at the time of the study might have helped with some of these chores and so have released the time of the nurses for functions requiring professional training such as counseling the family or immunization. The study thus indicated that the clinic might absorb an increase of as much as 20 percent in the patient volume without any additional professional time being made available.

Equally significant was the finding that 43 percent of the pediatrician's time was spent waiting for patients, obviously a great waste of a professional resource. From the viewpoint of time alone, the study thus revealed that a reorganization of this clinic's procedures was necessary so that maximum use might be made of the pediatrician's skill. In ensuing discussions between the authors and clinic administrators, it was pointed out that the clinic would be making better use of the pediatrician if (1) he saw more children; (2) he served more actively as a consultant to the nurses; (3) he performed a review of records as part of planned studies; (4) he conducted group meetings of the parents in the waiting room; (5) the clinic incorporated medical treatment into the program, thus using the pediatrician's time on curative as well as preventive aspects of child health supervision in a program of comprehensive care.

The finding on the amount of the pediatrician's time spent in waiting also raised the question as to the effect idleness nearly half the time might have on a pediatrician in any clinic. Would the pediatrician remain interested or become bored? Would he feel that he was an integral part of the clinic, or a rather unnecessary appendage?

Followup

Several steps have been taken in this child health conference as an immediate result of the time study. Prior to the study the pediatrician was considering whether the clinic might not profitably use another nurse. The time study showed that another nurse was not needed, but rather that the need was to use the time of the available nurses more productively. The plan is now to increase the amount of nurses' time

available to patients by training a volunteer to set up and dismantle the clinic, weigh and measure all children, and fill out the health department record. This step has been delayed by the resignation of the Neighborhood Youth Corps worker to take a permanent job elsewhere, thus depriving the conference of her services. Vigorous recruiting for a volunteer is in progress in the neighborhood of the clinic among mothers who are free during clinic hours because their children are in school.

Because of the finding on the amount of time the young patients and their mothers are spending in the waiting room, the nutritionist is spending more time in the waiting room with them discussing food-buying practices, general principles of feeding children and other problems. The group discussions of food buying, which include current prices, comparisons of the nutritive values of various foods, and many suggestions for varying the family menu, have proved especially popular. We now notice mothers who return to the waiting room after their children have been seen to continue to participate in the discussion.

A rescheduling of "physician visits" is now in process to allow better use of the pediatrician's time. Among the uses contemplated for this time are the provision of services to unreached segments of the community, increased consultation to nurses, teaching groups of mothers, and efforts to integrate the activities of the clinic with other community activities such as health programs in the local school and in the health services supported by the Office of Economic Opportunity. Already the clinic is making effort to encourage the previously unreached Spanish-speaking mothers in the neighborhood to bring their children in for well-child supervision.

Because of the demonstrated value of the time study as a method of self-evaluation in a well-child clinic, the Division of Maternal and Child Health of the University of California School of Public Health has been working with its students and with local health authorities to encourage the use of this simple tool. It seems to us that the time study would have particular value as a lever for raising the level of performance in those well-child conferences that have long waiting lists and long waiting periods for initial registration of infants after hospital discharge and also in those well-child conferences that are so overcrowded that they are designed for infants only and terminate service on the child's first birthday. Thus, a time study could be one device used in tackling the almost universal problem of "preschool dropoff" in well-child conferences.

an occupational therapist and a social worker combine their efforts in . . .

a HOMEBOUND THERAPY PROGRAM

for SEVERELY RETARDED CHILDREN

HOPE G. CURFMAN ● CAROL B. ARNOLD

● For the past year, 30 Denver families with severely and profoundly retarded children have been served by an unusual program combining the services of a professionally trained social worker and a registered occupational therapist. The program is unusual in two ways—it serves children not often reached by social agencies and it brings its services into their homes. The Easter Seal Society for Crippled Children and Adults of Denver, Inc., through its Sewall Easter Seal Rehabilitation Center, sponsors the program with the help of a grant from the Denver Board for the Mentally Retarded and Seriously Handicapped.

Giving each child an opportunity to fulfill his potential has long been recognized as a goal of education, but the right of the retarded child to the same educational opportunity has been slow to receive recognition. However, many public school systems now include special programs for mildly retarded children (IQ's of 55 to 67). Denver's school system, for instance, has had special education classes for children with IQ's of 50 to 80 since 1948 and last year served about 1,650 children.

But, until recently, few community resources were available to meet the training needs of children considered moderately retarded (IQ's of 36 to 51), severely retarded (IQ's of 20 to 35), or profoundly retarded (IQ's of less than 20). Financially able parents can provide care in private schools, but even for them the needs far exceed the resources. Parents with limited means have little choice beyond institutionalization or letting the child vegetate at home.

Only a few agencies can offer more than minimal service to those who keep their children at home.^{1, 2}

Recognizing that a gap existed between the programs offered by the public schools and the resources of the two State institutions for the mentally retarded, the Colorado Department of Institutions in 1964 requested a grant from the State Legislature for expanding resources for the mentally retarded, and received \$200,000. The money was to be allocated to boards incorporated by local communities to purchase services from existing agencies and to organize community centers for retarded persons in the community.

From this grant, the city and county of Denver was allocated \$27,000, and in August 1964 the Denver Board for the Mentally Retarded and Seriously Handicapped was incorporated to administer the fund. The board conducted a small project involving nine severely and profoundly retarded children, primarily to give some relief to the parents, for about a year. Following this, the board made a grant to the Sewall Rehabilitation Center to develop a homebound therapy program to help both parents and children.

The goals of the program are these: (1) To assess and develop the potentialities of each child, to help him function with some independence and, at a minimum, to help prevent further physical, mental, and social retardation in him; and (2) to help the family increase its understanding of its retarded child and thereby to contribute more to his development while learning to live more comfortably with the problems

he presents. According to the plan, these goals were to be met by combining the services of a social worker and an occupational therapist and, wherever possible, by providing services within the community so that the child might continue to live in his own home.

The social worker makes the initial contact with the family to gather pertinent information on its social history and to acquaint the family with both her services and those of the occupational therapist. After setting up an appointment, she and the occupational therapist call on the home together. During this visit, they try to explain their work to the family. The occupational therapist concentrates on what she hopes to accomplish with the child; the social worker, on what she can do to help the parents. At the same time, however, they work together as a team.

Objectives

As retardation is always a family problem, the social worker's first objective is to help the family find more acceptable or easier ways of living with a difficult situation. She varies her methods as the needs of each family require. Most parents need continual ego support because they often feel frustrated and hopeless. In some cases, the mother requires extra help because no father is living in the home. The social worker's task is to help the family face reality, to assess its strength, and to constantly support its members. When indicated, she introduces other community resources such as a hearing evaluation, physical therapy, or referral to a day-care center offering a structured program. After she establishes a relationship with the parent or parents, she introduces the services of the occupational therapist.

The complete picture of the child is taken into account in setting up individual aims for treatment. These aims are to help the child attain what skill he

can in performing the activities of daily living such as eating, dressing, and using the toilet; to help him make constructive use of toys; to help improve his motor and perceptual development; to provide support for the family; and to prepare the child for further training suitable to his ability.

1. *The activities of daily living.* For the profoundly retarded, the occupational therapist begins this training at the most primary level of functioning—feeding and drinking. Many of the children progress no further than learning to chew ground food and drink from a cup, but even so small an advance is important for nutrition and nursing care. Not all cases require training in feeding, but many parents can use suggestions for improving the eating habits of their children. The therapist offers training or suggestions as the case requires.

In some cases, the occupational therapist's aim is to improve skills ranging from putting on shirt and socks to buttoning large buttons. Many children can take off clothes, and if the mothers do not want this ability reinforced, no such training is given.

In regard to toilet training, the occupational therapist advises the mother about the length of time to leave the child on the toilet and how to give praise or reward for accomplishments and encourages her to have patience and perseverance. The cultural patterns of the homes have a direct effect on this aspect of training, and some mothers cannot cope with their children's problems because of shortcomings in their own backgrounds.

2. *Constructive use of toys.* In some cases the children have been deprived of opportunities to play with toys and, consequently, of the experience of learning through manipulation and oral stimulation.

Some families cannot afford to buy toys that the child would quickly destroy. Most of the toys the occupational therapist finds in use are unsuitable for the hyperactivity and roughness of many retarded children. Most mothers, however, are eager to know what types of toys they should give their children and the occupational therapist is able to help them select suitable playthings.

3. *Motor development.* With the profoundly retarded child who cannot even recognize a toy, the occupational therapist begins by using the idea of body image and the concomitant awareness of environment. She used, for instance, the sitting balance, standing balance, and the crawl position to exercise three of the most severely retarded children

Hope G. Curfman, left, and Carol B. Arnold until recently worked together as social worker and occupational therapist, respectively, at the Sewall Easter Seal Rehabilitation Center in Denver. Mrs. Curfman is now a social worker in the Denver public school system. Mrs. Arnold is now devoting full time to raising her two children. She was once director of occupational therapy at the State Home and Training School, Wheatridge, Colo.



helping children gain control of the head and trunk important because without it their visual stimulation is limited and they are difficult to feed.

4. Perceptual development. Perceptual training is limited to the area of tactual stimulation through the use of large puzzles, graded pegs, and materials of different consistencies such as cotton and sandpaper. The occupational therapist also uses games developed for culturally deprived and moderately retarded children such as picture lotto, clutes and adders, and candyland for teaching picture identification and color and form recognition.

5. Support for the family. In some instances, the parents have given up hope that anything can be done for their retarded child. Other parents are unrealistic in their expectations of what their child could do with some training. The homebound program gives the parents first-hand experience with the methods that could be used to help the child and an opportunity to see the progress or lack of progress in the child. After some experience with the worker, they sometimes begin to think of ways to help the child themselves. For example, several mothers have suggested the use of a walker or chair, and several of the more observant have learned *how* to play with their retarded children by watching the occupational therapist at work.

6. Preparing for the kind of training most suitable for the child. Whenever possible, the workers try to prepare the child to go into other programs such as the preschool group at the Sewall Rehabilitation Center or a group program for trainable older retarded children. They assist the families in making the transition in each case and supply the schools with helpful information.

Methods

During her first visit to the family after the initial interview with the social worker, the occupational therapist brings colorful and sturdy toys with her, including noisemakers and toys requiring dexterity and coordination, selected according to the information in the social history. On later visits, she ascertains what the goals are for each child and what equipment she needs.

Because all toys and equipment used in the homebound program have to be carried by automobile, some are heavy, bulky, or messy. But a small cutout table, a kindergarten chair, and a playpen pad are part of the standard equipment. The pad is inex-

pensive and easy to carry and makes it possible for the occupational therapist to sit on the floor with the child if he cannot balance himself on the chair. Depending on the case, she brings in a relaxation walker for use on trial.

The occupational therapist uses toys to promote the recognition of color, gross and fine coordination of the arms and hands, form perception, and so on: a color cone; two simple puzzles; a graded, round peg set; a nest of round color cups; a large ball; a squeaky animal toy; a button box; a string with beads; a pounding toy; and small blocks. She introduces other materials, depending on the child's needs and ability, such as scissors, paper and paste, clay, pictures, lacing projects, a loom, and games.

During the first visit the occupational therapist arranges a time for regular visits with the family every week. The agency makes an exception to a firm schedule if necessary, as in the case of a mother who works on shifts.

The mothers' group

In addition to bringing services into the home, the center also holds eight weekly 1-hour sessions in group counseling for those mothers the workers think would benefit from such an experience. In the original group, this was about half. The other mothers of this group participated in individual counseling only because the social worker thought they would not profit from group work or because they could not attend the meetings.

The mothers who attend the sessions bring their retarded children to the center, and while they are attending the session with the social worker, the occupational therapist conducts a simple program for the children divided into free playtime, snacktime, and project time. The free play introduces the children to the new situation, the clinical environment, and each other. Snacktime gives them an opportunity to practice table manners and to develop the ability to share with others. And the project time gives them an opportunity to learn simple methods of coloring and cutting and gives the occupational therapist an opportunity to observe their cooperation and interaction. However, because of the children's wide range of ability, this part of the program cannot provide the children with individual therapy. Nevertheless, providing this service simultaneously with the sessions has proved to be the best method of involving the mothers and of establishing the focal point on which the group discussions begin.

The goals of the group program for the mothers are these: (1) To provide specific help in living and dealing with feelings; (2) to create an environment in which feelings can be aired; (3) to provide specific help with practical problems of management; (4) to provide group support through the exchange of ideas between members of the group and the leader and to help minimize the feeling of isolation; and (5) to encourage the use of services offered by the center through the social worker-occupational therapist team and those of other community organizations.

The specific issues discussed at these sessions include ways of handling questions from others about "what was wrong" with the children; the need for "escape valves" for anger; methods of discipline and other problems of management; and long-range planning for the children. The mothers in the first group asked for a tour of the State institution for the mentally retarded near Denver and nine went on such a tour. At a meeting held after the tour in which they discussed their reactions and expressed their feelings, all nine said that they now felt better able to plan for placement of their children if necessary.

The center has decided that, on the whole, group counseling as a part of the program for the mothers who could profit is beneficial. The greatest achievements are the minimizing of the feeling of isolation, the passing on of practical suggestions for dealing with problems of management, and getting the mothers to discuss long-range planning.

Case illustrations

So far 30 families have been involved but only 20 at any one time. As a beginning, the board selected 20 cases after review by its admission committee. All 20 children originally selected were severely or profoundly retarded and physically handicapped and lived in their own homes (with one exception). All were evaluated medically and, if possible, psychologically, before acceptance. Their ages ranged from 3 to 18 years, the average being 8 years; their IQ's, from "untestable" to 50, the average being 24. All families of the children selected were living in Denver, and most were on the lower socioeconomic levels. They consisted, in almost even proportions, of Anglo-Americans, Negro Americans, and Spanish Americans. The medical diagnoses for the children reported the presence of Hurler's Syndrome, Down's Syndrome, microcephaly, postmeningitis, "brain damage," and "mental retardation, etiology unknown."

The following examples taken from these first 2 cases illustrate the methods used by the social worker and the occupational therapist in working with these children.

Peggy B and Larry S: These children present contrast, though both are about 8 years old, have about the same IQ—an estimated 20—and both function at about the 2-year-old level. Peggy has been diagnosed as having hypothyroidism, for which she is receiving treatment; Larry, as having organic brain damage with chronic otitis, mild conductive hearing loss, hypospadias, repaired cleft palate, and convulsions. Both children had very limited speaking ability.

In the case of Peggy, community resources were used to meet her needs while she lived in her own home; in the case of Larry, the goal was institutionalization. The need for different goals became apparent in working with the children and their families even though their functional levels are about the same. The workers determined that both children could profit more from the stimulation received in a group of other children with similar disabilities than from being at home all the time.

Larry S: The pressures of Larry's home increased his negative behavior. During the home visits, his mother would hover over him and prod him verbally. Though she said she knew his ability was limited, she was constantly seeking confirmation that he was improving. He needed to be out of this environment for therapy to be effective.

One of the aims for Larry concerned feeding, not as a function of motor ability, as Larry could use a spoon and cup, but to stimulate his poor appetite. After a visit during lunchtime, the occupational therapist decided that the mother was overfeeding the child and forcing him to eat larger portions than he should eat. She suggested that, since Larry enjoyed a large breakfast, his mother might omit the noon meal or make it very light and give him his main meal in the early evening.

Larry had good fine coordination, but, because his balance was poor, the occupational therapist emphasized activities involving gross coordination, activities difficult to offer in the home. Larry was uncooperative much of the time and would not perform the activities unless he wanted to end the therapy session. When the occupational therapist disciplined him for his actions by showing disapproval, by facial or body gestures and by spanking his hands, he would begin to follow instructions. He resisted efforts to

teach him to dress, however, because his mother had punished him for removing his clothing.

The social worker meanwhile was counseling the parents. Mrs. S, through the mothers' group at the center, was able to air her feelings regarding Larry and her problems concerning a younger cerebral palsied brother and a normal sister. Her husband, who was pressuring her to place Larry in the State institution, told the social worker, "It's either him or me." Mrs. S, in resisting this pressure, had developed stomach ulcers and had become obese from emotional overeating. She was extremely dependent on her own mother and felt torn by the demands of the two other children. After a single interview with the social worker, her husband let up on his threats. With the social worker's help, he recognized that he felt under tremendous financial pressure to provide for two severely handicapped children, that his real concern was over the effects of both retarded children on the normal little girl, and that the conflict over Larry in the home was becoming a wedge between him and his wife.

During a brief hospital stay for Larry, the mother realized how much calmer the home was in his absence. She also realized that the problem of caring for Larry would become increasingly greater. Recently she enrolled the normal child in a neighborhood cooperative nursery school and signed the application papers to the State institution for Larry.

Although there are still many unsolved problems in Larry's family, his parents have shown the capacity to act. The occupational therapist was able to demonstrate to the mother that she was making unrealistic demands on the child, and both workers helped her face his limitations. Family friction lessened, and a realistic plan for Larry and his sister was carried out.

Peggy B: Resources within the community made institutionalization for Peggy B unnecessary. The occupational therapist worked with Peggy on dressing skills, perception techniques, and increased hand coordination. At first, she found it difficult to motivate Peggy because of the child's dependence on her family, who loved and accepted her as "the baby" of six children. Her parents put no pressure on her to acquire new skills. However, she would usually try to complete the activities given her by the occupational therapist.

When the mother did not give Peggy her medication as prescribed by her doctor, the child was logy, uncoordinated, and unable to perform satisfactorily.

The occupational therapist pointed this out to the mother to impress upon her the need for the medication if Peggy was to improve. The mother was helped by the social worker to face her need to keep Peggy "the baby," and when the occupational therapist demonstrated to her that Peggy could acquire new skills, the mother seldom failed to administer the medication. She became active in the mothers' group at the center, and her opinion that the family could provide the loving care Peggy needed better than a large institution was reinforced by her tour of the State institution. This completely accepting family became interested in Peggy's activities and responded accordingly.

Larry's presence in the home caused mounting friction, but Peggy's was a focal point for family concern. After working with the two for several months, the workers felt that both children would gain from a group situation: A group would relieve Larry of the pressures of home and give Peggy more goals to attain. Both were, therefore, enrolled in the preschool group at the Sewall Center.

Donny P: This child, with an IQ of about 10, was diagnosed as being profoundly retarded and having bilateral glaucoma and mild seizures. He had spent 9 years lying in a crib, and was fed by a bottle. His mother, responsible for the care of nine children—five of her own and four of her deceased sister—had little time to spend working with Donny on new feeding skills; nor could she participate in the mothers' group.

When the occupational therapist tried to make Donny take food from a rubber-coated spoon, he resisted violently because he was not used to being held upright. Taking his age and blindness into account, the occupational therapist decided not to pursue the spoon feeding but rather to concentrate first on increased body balance and body awareness.

She next began working on sitting and standing balance and head control. At first, Donny was unable to bear any weight on his feet but would crumple to the floor; nor could he sit up straight. After the occupational therapist had worked 6 months with him, he stood with support and was bearing weight for about 5 minutes. After observing the occupational therapist's work with Donny, the mother and older children started working with him. The occupational therapist introduced the idea of a relaxation chair to try out with Donny. She explained that even though Donny was profoundly retarded it would be stimulating to him to be in the

living room with the family and that it would help him to change position from constantly lying in bed. When the family showed interest, the social worker procured the chair, made to specifications, from the Goodwill Industries.

Johnny F: In the case of Johnny, a 3½-year-old child of about the same mental age as Donny but with eyesight, the services of the homebound program did not meet with success. The father had deserted his family, and the mother, plagued with severe emotional problems, rejected Johnny.

A child welfare worker from the public agency had prepared Mrs. F for the homebound program, but she was unable to accept the service. Ambivalent at first, she did make feeble attempts to work with the occupational therapist on feeding skills. But she consistently broke appointments. Many other family problems complicated the issue and drained the mother's limited capacity. The only contribution the program could make was to provide additional diagnostic material for the child welfare worker in her long-range plans for the family.

Lloyd II: A 9-year-old boy diagnosed as having brain damage following meningitis, Lloyd II was at first hostile and uncooperative. He had previously been placed in a preschool age group for severely retarded children, but he had regressed to the point of wetting his pants, spitting, sitting on his hands, and banging his head. The occupational therapist spent most of her time during the first month's visits talking with the mother and letting Lloyd get use to having her in the home.

She used Lloyd's interest in playing ball as the focal point for working with him, and she developed many variations—tossing balloons, bouncing clay, and hitting a punching toy. He began to talk, and though his speech was unintelligible at first, in a few weeks phrases such as "bounce the ball" became clear. He soon gave up wetting his pants, though he continued to sit on his hands until the last month of the program. Although he continues to hit himself when frustrated and angry, his mother has become more aware of ways to channel his negative behavior, and she is helping him overcome this reaction.

The role of the social worker in relation to Mrs. H was to help increase this mother's understanding of her retarded child's behavior, to help her find acceptable ways of releasing her feelings, to help her substitute positive for negative methods of disciplin-

line, and to reinforce the activities of the occupational therapist. Mrs. H was a member of the mothers' group and was also seen individually by the social worker.

Seven of the children in the first group in the homebound program became involved during the year in other training programs such as Sewall's preschool group, a program for trainable older retarded children, and a program at a training school. Late in the program, two children were accepted by a private school for exceptional children, one was referred to a cerebral palsy center, and another to Sewall for further evaluation and intensive therapy.

Evaluation

As with any new program without a chartered course, problems have occurred. Some problems are inherent in the program itself. As the program centers on the severely and profoundly retarded child, only very small gains can be expected. Several of the children who have been involved are so severely retarded that the only movement is regression.

Compensations are found, however, by the staff members in the favorable responses of the parents to the program. In it the parents see something specific being done for their children, and usually they can see some progress. They frequently say to the workers, "At last someone is doing something for Susie," or "Stevie looks forward to your visits."

The program is continuing in cooperation with other agencies in much the same way. Emphasis at this time is on group stimulation for the children.

A program such as this does, in part, fill the gap between programs offered by the public schools and State institutions. Most of the children served are continuing to live in their own homes and are receiving therapy geared to their individual needs. At the same time, families are being helped to live more comfortably with the problems of a retarded child in the home. Apparently, the entire needs of the family with a retarded child are better met by the combined services of the occupational therapist and the social worker than they could be by either working separately.

¹ Dittmann, Laura L.: Home training for retarded children. *Children*, May-June 1957.

² Cianci, Vincentz: Home training for the mentally retarded. *Children*, May-June 1955.

a social worker
from a
child guidance
clinic provides . . .

GROUP COUNSELING of MOTHERS in an AFDC PROGRAM

DAVID KEVIN

Several months ago, a psychiatric social worker in a child guidance clinic (the author of this article) conducted a 6-month demonstration in group counseling of mothers selected from a public assistance caseload because of evidence that they were inadequately caring for their children. The results seemed salutary enough for this type of approach to the protection of children to be given serious consideration as a complement to individual counseling both by child guidance clinics and by public welfare agencies.

The Protective Services Unit of the Alameda County Welfare Department from which the mothers were selected was established in 1961 to provide more intensive services to families on public assistance, especially in the program of aid to families with dependent children (AFDC), in which there was evidence of neglect or inadequate child care. As part of its intensive services to these families, the unit became increasingly active in making referrals for psychiatric evaluation and psychotherapy to the East Bay Clinic for Child Psychiatry operated by the California State Department of Mental Hygiene.

Gradually it became evident to the clinic's chief psychiatric social worker that all the families referred had multiple social and economic problems that were integral parts of the children's emotional and behavioral difficulties. It also became evident that the child referred to the clinic might not be the most upset child in the family.

Like most clinics serving children, the clinic used a lengthy evaluation procedure. It, therefore, seemed possible that many cases referred to the clinic by the welfare department dropped out because of the time involved and because of the failure of the child's mother to understand the evaluative process. At any rate, many evaluations were never completed because the mother and child never returned. This fact seemed to imply that a more appropriate approach needed to be taken to these families.

The psychiatric social worker, therefore, proposed to conduct a demonstration of group counseling of the mothers of children referred from the Protective Services Unit for treatment, in place of evaluation and treatment of the children. Two hypotheses underlay this proposal:

1. Through group counseling, the mothers would be able to improve their ways of coping with their difficulties.

Based on a paper presented at the 1966 meeting of the American Orthopsychiatric Association.

2. The effects of counseling the mothers only would noticeably alleviate the children's behavioral difficulties in school and in the home.

Reports from the unit workers and the mothers themselves were expected to provide necessary information about the adjustment of the children.

Initial planning stage

The first step was a discussion between the psychiatric social worker and the supervisor of the Protective Services Unit to work out plans for its implementation. Both agreed on the necessity for bringing the child welfare division's administrators into the initial planning, and therefore arranged for the chief and the assistant chief of the division to meet with them on several subsequent occasions. In these meetings, the possibilities of the proposal were explored fully from the viewpoints both of the welfare department and of the clinic in relation to the demands on the time of the unit's workers, the potentials for inservice training, and the possibilities of eventually incorporating the group counseling method into agency structure. The result was an agreement that the clinic would undertake the proposed experiment with the help of the division and that the administrators of the division would be kept informed of its progress.

The next step was for the psychiatric social worker to hold a short series of meetings with the supervisor of the Protective Services Unit and the unit's four workers to determine criteria and methods for selecting mothers for the project; to discuss problems related to the confidentiality of information that would come out in the discussion group, especially information that would have a bearing on the mother's eligibility for public assistance; and to work out methods for training the workers for the group leadership task. The criteria for selection agreed upon were:

1. The mother would have to be the head of the family. The selected mothers would be those responsible for the care and management of their children in their homes. Therefore, unwed mothers who lived with their own mothers would be excluded.

2. The mother would have to have a child or children under teen age. The exclusion of mothers who had teenage children only was based on the theory that little change could be brought about in teenage children through counseling their mothers only.

3. The mother would have to have at least one

child who was showing behavior problems at home or at school.

4. The mother had to be stable enough emotionally to be able to relate to other mothers in a group. Mothers who appeared to be severely retarded or disturbed were excluded because it was imperative for the group members to understand each other.

5. The mother would have to be between the ages of 20 and 40. Those who were younger were excluded as likely to be living with their parents. Those who were over 40 were less likely to have young children and more likely to be fixed in their attitudes toward child rearing.

6. The mother would need to have ready access to public transportation because transportation difficulties could discourage attendance.

Following the establishment of the criteria, there was general agreement that each worker in the unit would contact all the mothers in his caseload who fulfilled these criteria, inform them of the possibility of joining this type of group, and encourage their voluntary participation.

The question of confidentiality was regarded as posing no problems because the psychiatric social worker, who was to conduct the group counseling, had no official relationship with the welfare department. However, if any questions were asked by the mothers relating to eligibility, the mothers were to be referred by him to their public welfare caseworkers for additional information or clarification.

The 6-month time limitation was set on the basis of several assumptions: (1) That the mothers would have trouble making arrangements for a longer period of time for transportation to the clinic and for the care of their children while they attended the meetings; (2) that they would have difficulty remaining absorbed in a group for a longer period, particularly one extending into the summer when their children would be out of school; (3) that 6 months would be a sufficiently long time to produce evidence of change if any were to occur.

Group composition

The unit workers suggested participation in the group to 34 mothers and pointed out that this was an opportunity to talk over their problems with other mothers in circumstances similar to their own and that through such discussion perhaps find better solutions for their problems in child rearing and home management. Ten of these mothers—eight Negro,

one Mexican American, and one Caucasian—agreed to participate. They included:

- Four mothers housebound by chronic depression so severe that they could not maintain their households or provide even minimal care for their children.
- Two extremely hostile and suspicious mothers who were overtly aggressive toward the welfare department and its workers and who in their child care were rigid and demanding.
- Two mothers who had had psychotic episodes: one was undergoing a severe depressive reaction; the other was so ambivalent that she was unable to make decisions.
- One mother with a severe drinking problem and a marked speech difficulty.
- One mother who frequently suffered from psychosomatic ailments such as allergies and headaches.

The psychiatric social worker sent each mother a letter informing her of the purpose of the counseling sessions and the date and hour of the first session and inviting her to attend.

The attendance fluctuated markedly until the end of the third month, at which time the group's membership stabilized at seven. The three mothers who dropped out were the most ambivalent and suspicious in the group. One had marked difficulty in transposing experiences into words.

There were several practical problems that influenced attendance: (1) Numerous medical appointments for the mothers of children at the county hospital that conflicted with the hours of the group session; (2) a long rainy spell that discouraged those who had to wait for buses; (3) unexpected difficulties in arranging child care; and (4) a 3-week illness on the part of the psychiatric social worker. By the end of the third month, most of these obstacles had been overcome.

The psychiatric social worker's role as group counselor varied with the stages of group development, the themes of the discussion, and what happened among the members. However, he always provided an urn of coffee for each session, thus showing the group that he could accept them and give to them without making demands. Taking coffee together provided the group members with a pleasant way to begin each session, helped them warm up to the group gradually, and offered the counselor an acceptable excuse for a break when the tension became too high for one of the members to tolerate. It also provided the counselor with some insight into the nature of the members' social interactions.

For example, in one of the early sessions of the group, the leader invited the members to have coffee. All except one went to the coffee urn and chatted about how nice it was to have the coffee available. Although it was only 11:30 a.m., the mother who refused coffee said that it kept her awake. In this way she seemed to be informing the leader that she could not be bribed by an authority figure as could the others. However, later on after the psychiatric social worker had focused the group's attention on her child-rearing problems, thus giving her an opportunity to voice her frustrations, she arose to get herself a cup of coffee.

Recurrent themes

One recurrent theme in the earlier group sessions dealt primarily with problems of child management and discipline. While on the surface these problems did not seem different from those encountered in normal parent-child relationships, discussion revealed them to be much more intense and, in some cases, symptomatic of pathological relationships that seemed to arise out of the mothers' status as heads of poverty-stricken, fatherless families.

Most of the mothers felt overwhelmed by the necessity of having to take on the roles of both mother and father and by the never-ending, unrelieved demands of their children for attention, discipline, affection, understanding, and time. They had responded to this feeling in one or more of the following ways:

- Placing older children in quasi-parental roles in relation to themselves and their younger children.
- Becoming overly critical of their children, especially the boys, and demanding that they be inordinately obedient and quiet, with the results that younger children became infantilized and adolescents reacted with rebellion often expressed in antisocial behavior.
- Being unconsciously seductive with an older son, an attitude that either led the boy to leave home or to become feminized or both.
- Becoming competitive with a daughter who had given birth out of wedlock and taking over the mother role for the daughter's child.
- Sinking into a state of hopelessness and apathy.

A second recurrent theme had to do with the mothers' feeling that they had married or had alliances with men who were weak, ineffectual, deceiving, brutal, or alcoholic. There was, in fact, a recurrent hostile ridiculing of men in general as manipulative

toward women and as having one goal only in mind, their own sexual gratification.

A third recurrent theme was connected with the mothers' methods of coping with a hostile environment. They painted black pictures of official institutions—particularly the welfare department and the county hospital—and their staff members. One widespread complaint was against the constantly changing public assistance workers, who, they implied, knew less about people's legal rights, privileges, and limitations under the welfare and institution code than the clients themselves. They repeatedly told of arriving for early morning appointments at the county hospital and being kept waiting all day and even sometimes being asked to return the following day. They also expressed hostility toward the public utility companies and retail credit stores. In the mothers' minds there was apparently little difference among all these "enemies."

A fourth theme concerned difficulties in getting credit and in shopping for and preparing food.

A fifth theme dealt with the purposes and effects of the group meetings.

Counseling techniques

In counseling the group, the psychiatric social worker used an approach primarily directed toward helping the mothers increase their coping capabilities. He, therefore, encouraged them to discuss their experiences and frustrations with each other. When they did so the group members became closer to each other as they found they had common experiences despite their different ethnic and cultural backgrounds. Following the establishment of greater empathy among them, the worker encouraged them to exchange information about their methods of dealing with their problems. He asked direct questions about how they shopped, how they prepared food, how they disciplined their children, and the like. This type of guided activity helped keep their attention focused on difficulties relevant to child rearing.

Only rarely did the worker feel it necessary to directly support the mothers' feelings since the mothers were supportive as well as directive in their comments to each other. For example, the previously psychotic mother who was so ambivalent and indecisive in dealing with her children was told by members of the group that they would not tolerate constant whining demands from their children. They pointed out that her way of saying two opposite

things to her children at the same time was confusing to them and to herself.

While the worker rarely focused the discussion on feelings as such, the mothers' cathartic expression of feelings of futility, rage, and cynicism tended to reduce the strength of such feelings. As a result, the members of the group became able to differentiate among the targets of their hostility more realistically. In so doing, they tended to modify their perception of public assistance workers and began to see their workers in the Protective Services Unit as being well informed, capable, and genuinely interested in their welfare.

Late in the group's existence, after several mothers had reached the point of feeling some sense of mastery over their environment, a few of them became involved in community organization activity through a neighborhood community action program. They worked to reduce vandalism in their neighborhoods and to attain more nearly equitable rents and better maintenance from their landlords. The group counselor encouraged them in this activity and in discussing its successes and failures. He also encouraged them to discuss additional steps they might take to better their living conditions.

When the mothers expressed bitterness at exorbitant interest rates in credit buying, the counselor asked them whether they would like to have an expert on credit speak to them. They responded with enthusiasm, and so the counselor invited a representative of a credit union to talk to them at a subsequent meeting. Similarly, when the mothers discussed food shopping and preparation, the counselor arranged for a home economist from a consumer's cooperative to speak to them. Obviously, the kind of practical information taken for granted by middle class housewives had never been made available to these mothers. The counselor believed that it could not only help them with their day-to-day management problems, but also could help build up their self confidence.

Group interaction

The members of the group seemed puzzled at the early meetings. Their interaction with each other was highly tentative. They gave most of their attention to the counselor with the implicit expectation that he would behave like most of the middle class authorities they had encountered—that he would be critical and tell them how to run their lives and to solve their problems. They were surprised and

even resentful when he did not respond in this manner but left it up to them to work out their own problems.

As the mothers turned to each other and each carried the dual role of helper and helped, they became freer in revealing their current and past relationships and difficulties. They went beyond looking for methods in child rearing and began to seek reasons for their attitudes toward their children. For example, one mother came to see that because of feeling that she was getting nothing for her efforts she could not praise or encourage her children, who were, therefore, in constant search for attention and not particular about the kind they received.

The mothers moved from a sensitive embarrassment at their common status as recipients of public assistance to a pride in being a member of a group of mothers who were working together to solve their problems. They expressed the feeling that because they were trying to influence their own lives they were different from some other mothers in the AFDC program. They also saw themselves as different from mothers who were not on public assistance.

As the sessions progressed and the mothers told about how they were trying to solve their problems, the influence on the others of the verbally dominant members of the group became apparent. Therefore, when the counselor learned that a member of the group had achieved some success in attacking certain problems of child rearing, home management, or interfamily relationships, he asked that member to tell the group about her experience in detail.

As the members of the group became better acquainted, some of them began to stay on for another cup of coffee and for a chat after the session had officially ended and the counselor had left. First, two or three members stayed and later most of the group. These postmeeting gatherings led to real friendships among some of the members. What might seem to be an unimportant social experience was an important advance in socialization for these isolated mothers, one that helped them achieve a greater sense of identity as persons in their own right.

Mothers' assessments

In the final sessions, the counselor attempted to get the members to assess their experience in the group and its meaning to them. This turned out to be a very difficult task for them. They seemed to be very much embarrassed, as if unaccustomed to looking objectively at themselves in a specific situation.

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They did, however, express appreciation for having a time for themselves once a week free from household chores and the demands of children and a place to go. (Few people realize how rarely mothers in the AFDC program have a chance to go anywhere.) Some of them also reported, directly or indirectly, one or more of the following effects of their participation in the group on themselves or their children:

- Some change in attitude on the part of the mothers toward their children: More consistency in their discipline, less perfectionism, more generosity with praise, and less criticism.
- Some evidence of changes in the children's behavior: Better behavior in school—or at least fewer complaints from the school about the child's behavior—and less tension in the home.
- A lifting of depression and apathy with resultant increased activity in home and neighborhood. (This was especially apparent in the four mothers who had become active in neighborhood work.)
- Increased understanding of their rights, privileges, and responsibilities under the welfare laws. Some of the mothers attributed this to the interchange during their postmeeting discussions.
- A lessening of a sense of guilt over being a recipient of public assistance.

Thus, the oral reports of the mothers themselves indicated that the group experience had provided them, in varying degrees, with more accurate knowledge of their environment and ways to deal with it, more accurate perception of their relationship with their workers, their neighbors, or persons in authority, and better tools for coping with the environment.

In the area of personal relationships, the mothers' reports indicated some increase in understanding of their children's needs for more individual attention, for more commendation, for less unrestrained criticism and punishment, and for more consistent firmness in relation to unacceptable behavior and in-

creased ability to see their children as individuals with individual personality needs.

Improvements in areas of ego mastery were indicated by their movements from pronounced social and emotional isolation to involvement in neighborhood and community affairs.

In symptomatology, the mothers' reports indicated pronounced decrease of depressive reactions.

Workers' observations

The more objective reports from the unit workers confirmed the reports of the mothers. They received direct evidence from the schools and hospitals regarding improved attendance and behavior. They saw positive changes in home management reflected in greater neatness and care. They saw positive changes in self-care and dress in the mothers. They found evidence of less tension in the households. They observed the involvement of some of the mothers in neighborhood councils and even in spearheading social action, such as getting out petitions for a larger rental allowance in their budgets.

The following are excerpts from the workers' observations made a month after the group ended:

Mrs. J: She is more accepting of the idea that her children's behavior is connected with her relationships. She no longer projects the blame onto the school, the public welfare department, or the children's father. Her teenage daughter, Delia, formerly a frequent runaway, has not left home during the past 4 months, and has completed her school year with the help of the home instructor and will be accepted in the regular school session in the fall.

Mrs. M: Before her participation in the group, she was frequently depressed and unwilling to get out of bed. She seemed on the verge of another mental breakdown. Her children were doing poorly in school and their attendance record was very poor. Her house was unkept. After participating in the group, she asserted herself with agency staff members and other people. She can now express her feelings and talk about her problems. Her depression is barely noticeable. She has become involved in the activities of the Economic

Opportunity program in her neighborhood and in the Boy Scouts program. She feels more worthy and her children are proud of her community work. She is now able to control her children and is clear about her parental role. She feels she has some control over her own and her family's destiny.

Mrs. C: She has shown a most dramatic change in her personal appearance, in her abilities to manage her household activities, and in her relationship with her children. She is able to discuss her problems freely now and to ask questions when she is confused. Before participating in the group, she never had visitors. Within the past 3 months she has become involved in a neighborhood improvement group that has met at her home. The most important change in her children is their good school attendance.

In addition to the two major hypotheses on which the project was based—that group counseling of the mothers only would (1) improve the mothers' coping mechanisms and (2) alleviate the behavioral difficulties of their children—the project tested a number of implicit assumptions. These were that people from the lowest socioeconomic bracket could become fully involved in sustained treatment, could achieve a degree of motivation that would provide an impetus to attend sessions regularly and on time, and could achieve an intense involvement in treatment without making a money payment. There was also an implicit assumption that for these achievements the treatment approach to this group required a wide flexibility than conventional group psychotherapy. All of these assumptions seemed valid for the group of mothers who participated in the demonstration.

It would be of great pragmatic consequence to have this type of demonstration replicated. If similar results were obtained with similar groups, they would strongly indicate that this type of group approach as a complement to the individual efforts of public assistance or protective services caseworkers, holds real promise for helping many mothers in the AFDC program cope with the kinds of problems that impeded their ability to provide appropriate care for their children and thus for helping them improve the quality of their own and their children's lives.

Always a way must be found for bringing into one's solitary place the settled look from another's face, for getting the quiet sanction of another's grace to undergird the meaning of the self. . . . Here at least one is dealt with, encountered, vanquished, or overwhelmed—but not ignored. It is a strange freedom to go nameless up and down the streets of other minds where no salutation greets and no sign is given to mark the place one calls one's own.

Whitney M. Young, Jr., to the International Conference of Social Work, Washington, D.C., September 1966.

YOUTH and YOUTH SERVICES in ENGLAND

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British youth today—especially English youth—are not only the fashion models but in many ways also the behavior models of our own young people. Their haircuts (or lack of them), their miniskirts, their motorcycles, their music, many of their freewheeling ways have been adopted with gusto by the teenage generation in this country. Whether much of what our Anglophile youth are avidly importing is actually a reimportation of American exports (as in the realms of music and fashion) may be debated, but what is clear is that the teenagers on both sides of the Atlantic often have more in common with one another than with the adult generations of their own countries.

Therefore, when I visited England shortly before last Christmas, I was particularly eager to learn what the young people there were really like and what special services had been devised to help them meet their problems.

Actually, except for speech differences, including some differences in teenage slang, the English youth seemed very much like their American counterparts. And Carnaby Street, the mecca of the teenage fashion world, seemed no more "far out" than 14th Street or off-main street, U.S.A., except for the studied Edwardian or Regency dress of its salesclerks.

Nowhere apparent among the young people I saw was the once celebrated

English reserve; they spoke their minds freely, and boys and girls openly expressed their affection toward one another by walking together hand in hand, arm in arm, or even with arms around each other. This boy-girl behavior, charmingly devoid of self-consciousness, seems to be characteristic of the young people in all the social classes and to be calmly accepted by their elders as a sign that the English have finally got rid of their prudery and are now catching up with their more demonstrative French and Italian neighbors.

The class consciousness of the older generation, I was told, has also almost vanished among the young, due largely to the changes in the educational system that came with the Education Act of 1944 and made ability rather than birth the touchstone for opening opportunities for a high-quality education. But there also seemed to be some feeling that class consciousness has not so much disappeared as changed into consciousness of strata based on educational achievement—the "outsiders" now being those who for one reason or another, not always a lack of native ability, fail the various examinations that open or close the doors to grammar (college preparatory) school, technical school, or the kinds of jobs that lead to something.

Most of the problems worrying adults about the younger generation were familiar to American ears: juvenile delinquency, out-of-wedlock parenthood,

sexual promiscuity, functional illiteracy, LSD experimentation, or just a general hedonistic attitude. But there were some differences:

- Unemployment among noncollege educated young people is not the problem in England that it is here. Almost anyone can get a job on leaving school, but many jobs for the unskilled are dead ends just as they are here.

- Proportionately, far more young people in England than in this country leave school at age 16 or under. About two-thirds of the young people in England leave school at age 15—the age that frees them from compulsory school attendance—most of them with an education somewhat comparable to that achieved at the end of junior high school here; while in the United States 72 percent of our young people finish high school. Only 8 percent of the young people in England go on to a degree-giving college or university, as against 38 percent of the young people in this country.

- Homosexuality, though probably not a greater problem in England than here, is certainly more talked about as a problem—increasingly as one requiring sympathetic attention.

These were the problems I heard mentioned most. But I also heard praise for young people's spirit of independence and freedom of expression; their determination not to be "had" by the purveyors of specious values; their des-

perate wish to make something of their lives.

What is there to help them?

Educational opportunities

First there are the opportunities for continued education offered by three types of government-supported colleges: (1) The regional colleges, which are open to all who can pass various examinations and which offer some technical courses and some university preparation; (2) the area colleges, which offer advanced academic programs to the academically eligible and numerous extension courses to others; and (3) the county colleges, which offer a wide range of vocational or life-enriching continuation courses to anyone who wishes to enroll. A great many teenagers in England who are out of school are taking courses of some kind somewhere, in efforts either to pass the door-opening examinations, to satisfy an interest, or to learn a trade. In fact, all young people under 18 who are employed may soon be required to take continuation courses related to their work, and employers may be required to give them time off to do so.

The Youth Service

Then there are the youth clubs, hundreds of them throughout the country, that provide young people with opportunities for bull sessions, social activities, the pursuit of hobbies, community service, and adventure. The prevalence of these clubs represents an interesting combination of government and voluntary efforts on both national and local levels. As in this country, England abounds in voluntary youth-serving organizations—Boy Scouts, Girl Guides, the YMCA, the YWCA, and a variety of sectarian organizations. Along with the local education authorities, these organizations, and their national associations receive grants from the national government for building up programs to provide “association, training, and challenge” to young people under 20, especially those who are no longer in school.

The Youth Service of the Department of Education and Science, through which these grants are made, was first established in 1939 to encourage the coordination of local services for young people and the provision of “new con-

structive outlets” for their energies. But after the war, it lost out in the competition for public funds so that by the late 1950's both the “constructive outlets” and the supply of persons to lead youth programs were obviously inadequate to meet the needs of a bulging, restless, teenage population. As a result of public concern, in 1958 the Minister of Education appointed a committee, headed by the Countess of Albemarle, to make recommendations on the Youth Service's role in helping young people “play their part in the life of the community” in the light of social change. This committee's report, issued in 1960, has breathed new life into the Youth Service and the programs it supports.¹

In addition to greatly stepped-up government financial support of the youth services of both the local education authorities and the voluntary organizations, the Albemarle report has resulted in—

- The appointment of a Youth Service Development Council to advise on the 10-year development of the Youth Service through two 5-year plans.

- The construction and improvement of clubhouses for young people, some as wings of modern secondary schools, some as student unions on the grounds of area and county colleges, and some as independent facilities operated by the voluntary organizations. Coffee bars, similar to our teenage canteens, abound, some as come-ons for diversified activity programs available to but not required of the young people who attend.

- The establishment at Leicester of the National College for the Training of Youth Leaders, with scholarships for teachers, social workers, and other mature persons interested in going into full-time youth service work; and the establishment or expansion by voluntary organizations or county colleges of training programs for part-time leaders. Through employers' associations, industrial firms have been asked to give interested employees time off from their jobs to pursue the courses for part-time youth leaders, and some have agreed.

- New experiments in programing with emphases on opportunities for service and adventure. Young people from all socioeconomic levels are working on a volunteer basis with the aged, the mentally retarded, the deaf and mute; they are serving as hospital aides, fire-

fighters, members of mountain rescue teams, members of a motorcycle emergency service. They are also climbing mountains just for fun, exploring caves going sailing, taking trips abroad.

- Increased efforts to promote greater opportunities for service by young people. Although many young people are engaged in volunteer community services, opportunities for such service are said to be far fewer than potential teenage volunteers. Therefore, a subcommittee of the Youth Service Development Council has proposed the establishment of local and national coordinating bodies, to include young people themselves, to promote interest in service by youth on the part both of young people and the potential users of their service, and to serve as clearing houses to bring young volunteers and opportunities for service together.²

- Efforts to learn more about the activities of “unattached young people”—those who can seem to find no place in society—and help them achieve satisfying group experiences based on their own interests. A 3-year study and demonstration project in this regard, sponsored by the Youth Service Development Council³ has provoked some controversy because the “detached workers” failed to reveal their purpose to the young people involved.

Youth participation

While there is much of the traditional self-conscious “character building” emphasis in the approach of some youth serving organizations, I think it is safe to say that the trend in England today is toward recognizing the modern youth's mistrust of anything in which he does not have a hand. Thus young people are being looked to more and more for participation in planning—as in the proposed coordinating bodies for promoting service by youth. And self-programing is the accepted practice in a great many of the youth clubs—particularly those attached to the various kinds of colleges.

The character-building goal is still held by the sponsoring organizations, but it is hidden in an approach that stresses the value of social interaction and mastery of skills in building the necessary base of self-confidence and self-respect. Thus theories of group dynamics, while still hotly debated in some quarters, are being given increas-

ing weight in youth leadership training courses. This emphasis on "social education" is, in fact, the rationale for keeping the Youth Service in the Department of Education and Science, which leans heavily on local educational authorities for developing services, to the consternation of some public welfare workers who regard leisure-time programs as social services and hence a responsibility of the Home Office.

The Albemarle committee's insistence on "challenge" is reflected in the variety of activities demanding the mastery of skill made available to young people through the youth-serving organizations at prices they can afford. And nearly every young person can afford a modest fee, for young people in England today, it was told, have more money in their pockets than any previous generation of teenagers. Participation in skiing, golf, sailing, mountain climbing, or travel no longer identifies a youth as a member of the upper or middle classes.

The emphasis on challenge is perhaps most clearly exemplified by the Duke of Edinburgh's Award Scheme, begun in 1956. Reaching young people not only through the schools and youth-serving organizations but also through a host of industrial firms that sponsor the Scheme for their young factory and office workers, it provides medals for "stickability" and achievement in four leisure-time areas: for boys, service, expedition, pursuits and interests (bird watching, photography, electronics, or whatever), and physical fitness; for girls, "design for living" (homemaking skills), pursuits and interests, adventure, and service. While the Scheme has been criticized for its heavy emphasis on physical prowess, it does include some special programs for the handicapped.

Consultation services

The government responsibility for individual and family welfare in England is lodged in the Home Office, but here again there is a close partnership between governmental and voluntary efforts. The link between the two from the point of view of the person seeking help is the neighborhood Citizens' Advice Bureau, an outgrowth of a wartime emergency service equipped to give anyone who walks in immediate information on where to go to get the kind of help he needs, whether from a govern-

ment agency, a voluntary organization, or even a commercial enterprise.

Young people whose obvious need is help with a personal problem may be referred to the county council's children's department, which with support from the Home Office offers services comparable to our public child welfare services; to a voluntary family advice service comparable to our family service agencies; or to a voluntary or public mental hygiene clinic. Adolescents in England are, however, as elusive as clients of casework agencies as they are in this country. Therefore, one innovative voluntary service in London, the Young People's Consultation Centre, is worthy of special note.

Dubbed the "worry clinic" by its young patients, this demonstration project is financed through the Youth Studies and Research Foundation by the Bernard Van Leer Foundation of Holland, and was established through the leadership of Mrs. Hilary Halpin. Staffed by psychoanalytically oriented psychologists and social workers, and part-time consultants from other disciplines as needed, it provides a drop-in counseling service to adolescents on their own terms. If the young person does not want to give his address or involve his parents, he does not have to. He can come back for future interviews or not as he chooses. The only question asked of the new patient by the receptionist is whether he wishes a man or woman counselor.

Some young people come to the Centre on referral from schools, social agencies, or employers; many come independently, for the foundation advertised the Centre's services in newspapers, coffee bars, libraries, youth clubs, and subway trains and stations. The response became so overwhelming that the ads were discontinued. The Centre's popularity has continued to grow as news of its services spreads by word of mouth and newspaper advice columns.

The foundation has announced the Centre's services as being for young people between the ages of 15 and 23, but adolescents as young as 12 have turned up and received service. Most of the young people who come to the Centre, however, are 17, 18, or 19. They bring a wide range of problems, some related to immediate crises and calling for simple advice or information, others stemming from longstand-

ing psychological problems of varying depth. Most derive from the gap between the youth's expectation of himself and his experiences in home, school, work, and love.

Personal problems

When advice or information cannot alone help the young person deal with his problem, the Centre's counselor may help him see the relationship between the problem and the emotional difficulties a person normally experiences as he gropes toward maturity. Often this is enough to relieve the strain the young person has been experiencing. For example, a problem frequently brought to the Centre by older adolescents is guilt about past homosexual activities. Most of the young people who come with this problem, however, have already moved beyond homosexual interests and need only to be helped to understand their past behavior as a not unusual manifestation of a phase in human development.

Many young people bring problems stemming from the social change that today accentuates the difference between the generations. For example, a university student told of suffering from constant criticism from his father, a dockhand who could not understand his son's scholarly interests and accused him of being less than a man. The student wanted to leave home, but feared hurting his parents. He was helped to see how he could leave and still maintain a supportive relationship with his family.

Other problems frequently brought to the Centre are worry about extramarital relations, pregnancy out of wedlock, and depression rising from a series of misfortunes—parental indifference, failure at school, a broken love affair. If the young person shows signs of suicidal tendencies, an organization called the Samaritans, which provides 24-hour service, may be called on for help. Pregnant girls are referred to appropriate medical and social resources, but the Centre frequently continues to work with them around the emotional problems that may have led to their difficult situation.

The Centre sees most of the young people who come to it only two or three times. Its original plan was to refer all whose problems were deeply imbedded in their personalities to other

agencies for psychiatric treatment, and many are so referred. However, because of a scarcity of agencies geared to offering this type of help to adolescents, the Centre is now providing some young patients with psychotherapy or psychoanalytic treatment through a panel of cooperating psychotherapists and psychoanalysts.

Another innovation in consultation services to young people is represented by the two Brook Advisory Centres for young people who "want to discuss birth control and sexual or emotional matters." These centers were established largely through the efforts of Mrs. Helen Brook, a board member of the voluntary family planning organization who was distressed by its policy—and the policy of the National Health Services—of refusing contraceptive advice to young unmarried women and girls. The purpose of the centers is to reduce the number of illegal abortions and illegitimate births and to inculcate a sense of sexual responsibility in the young.

The young women who come to these centers—often hand in hand with their young men—are not only given individualized contraceptive service but also an opportunity to discuss the quality of their sexual relationship and the emotional problems surrounding it. The girls return at 3-month intervals for thorough physical examinations and reviews of their total life situation.

Every girl who comes to the Brook Centres receives a pregnancy test, and some come because they fear they are pregnant and know the tests are available. Even if the fear proves unfounded, it is often the opening wedge to helping a girl with emotional problems. When indicated, girls are referred to psychiatrists for treatment or to clergymen for spiritual advice.

Sex education

At what age and by whom sex education should be provided to young people is a matter of debate in England, as it is here. It is, however, offered at some stage and in some manner by most of the "maintained schools"—those operated by the local authorities. There is also some experimenting in this direction by voluntary organizations and church groups. One of these, the Catholic Consultation Service, grew in a few years from a service of direct

counseling offered to individual boys by one priest into a widespread network of individual and group consultation services for boys and girls, a leadership training program for teachers in parochial schools, and a training program for parents. According to the Reverend Maurice O'Leary, the founder and director of the organization, schoolteaching nuns are much more responsive to this program than are schoolteaching monks. He believes this is evidence that boys are more neglected than girls in this respect.

Unmarried mothers and delinquents

One out of 14 children born in Great Britain is born out of wedlock⁴ (almost the same as the ratio in this country—1 in 15 in 1964). I have no figures as to what proportion of these are born to teenagers, but there is enough concern about schoolgirl pregnancies for a national conference on the subject to have been held in London last year. A concern at that conference was one also demanding increasing attention in this country—how to provide continued education for girls who become pregnant under school-leaving age. Apparently only a few local educational authorities offer opportunities for this.

As in this country, there are in England a variety of public and voluntary services for pregnant girls and unmarried mothers and their children—public assistance, shelter care, maternity care, social casework, and adoption services. At least one organization, the Church Army, is providing counseling to young unmarried fathers. But serious gaps in service still exist, as they do here, particularly in relation to the unmarried mother who keeps her child.

A major problem in England is finding housing accommodations for such fatherless families. Because so few local housing authorities include unmarried mothers and their children on their housing lists, some voluntary agencies are providing special "bedroom-sitting room" residences or "flatlets" for them.

The voluntary organization, the National Council for the Unmarried Mother and Her Child, is comparable to our National Council on Illegitimacy except that, in addition to working for public understanding and better services, the British council provides some direct help to pregnant girls and unmarried

mothers and their children. At present the council is working for better state financial provision for fatherless children and a wider variety of public social services "to compensate them for their disabilities." It is also advocating the establishment of local authority family services supported by the Home Office.

This last recommendation is one evidence of growing interest in building up the social services provided by the local authorities with the goal of strengthening family life—and so strengthening the stability and moral fiber of the young. This is a stated goal in a white paper issued by the Home Office in August 1965 recommending sweeping changes in the handling of juvenile delinquents.⁵ It recommends the appointment by each local authority of a family council, composed of representatives of the local children's department and others with a special understanding of children, to make decisions on the treatment of juvenile delinquents under 16, except in cases where the facts are in dispute or the council's recommendations are not complied with. This proposal, needless to say, has met with some criticism from legal quarters.

The white paper also recommends the establishment of courts for young offenders between the ages of 16 and 21—a proposal that has also met with some adverse criticism for taking young people between 16 and 18 out from under the "care, protection, and parole proceedings" provided for by the Children and Young Persons Act of 1963.

Ferment and change

One impression that anyone who makes even the most superficial review of services to young people in England must surely come away with is a sense of ferment and change. I have briefly described some of the developments learned about on my visit, but even as I describe them they are changing with the needs and moods of the times.

Legislation now before Parliament suggests there may be changes in policies of the National Health Service regarding the physician's role in giving contraceptive advice to unmarried persons.

In 1970, the school-leaving age will be raised to 16, and by then the sharp division between grammar school and secondary modern school, so criticized as the creator of new status distinctions

ions, will no longer hold as the two are merged into the comprehensive schools now being pushed by the Labour Government. By then too the hotly debated proposals for handling juvenile delinquents may have been put into effect or modified. Perhaps too the new voluntary experiments in offering individual and group consultation for troubled young persons, which now seem so limited to London, will have caught on and spread to other areas.

I think it is safe to say that unless there is an unlikely reversal of government support for group programs for youth, both the quantity and variety of opportunities for young people to develop their capacities as social beings will in the next few years greatly increase. Certainly today England more

than the United States recognizes government responsibility for supporting young people's development through providing them with opportunities to participate in challenging activities with others. Our Nation has thrown its spotlight on young people who get into trouble with society or who have other serious problems, as well as on the talented young people who are natural leaders. But what about the millions in between?

One thing about the future is clear. Not only England but also here and all over the world there will be even more teenagers than there are now. And *they* will have new ideas and wills of their own. And the adults there, here, and everywhere will be hard put to keep up with them.

¹Ministry of Education: The youth services in England and Wales. Report of the committee appointed by the Minister of Education in November 1958. Her Majesty's Stationery Office, London. 1960. (Reprinted 1964.)

²Department of Education and Science: Service by youth. Report of a committee of the Youth Service Development Council, December 1965. Her Majesty's Stationery Office, London. 1966.

³Morse, Mary: The unattached: a report of the 3-year project carried out by the National Association of Youth Clubs. Pelican Book A-737. Penguion Books, Harmondsworth, England. 1965.

⁴The National Council for the Unmarried Mother and Her Child: Annual report, April 1965-March 1966. London.

⁵Home Office: The child, the family, and the young offender. Her Majesty's Stationery Office, London. August 1965. (Reprinted 1966.)

guides and reports

MARSHALLING COMMUNITY SERVICES ON BEHALF OF THE ABUSED CHILD. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 80201. 1966. 30 pp. 35 cents.

Three papers given at the 1966 meeting of the National Conference on Social Welfare. The first analyzes State laws for reporting child abuse; the other two report on the implementation of reporting laws in a State-administered child welfare program and in a county-administered program.

WELFARE AND WISDOM: lectures delivered on the fiftieth anniversary of the School of Social Work of the University of Toronto. Edited by John S. Morgan. University of Toronto Press, Toronto, Canada. 1966. 184 pp. \$5.

Contains eight lectures on welfare in relation to social, economic, and political development by four scholars: T. H. Marshall, professor emeritus of sociology, University of London; Eugen Pusić, professor of public administration, University of Zagreb; Malcolm Adiseshiah, economist from India and

deputy director-general of UNESCO; and Charles Frankel, U.S. Assistant Secretary of State for Educational and Cultural Affairs.

PSYCHOPATHOLOGICAL DISORDERS IN CHILDHOOD: theoretical considerations and a proposed classification. Committee on Child Psychiatry, Group for the Advancement of Psychiatry, 104 East 25th Street, New York, N.Y. 10010. 1966. 343 pp. \$3.50. Discount on orders of 10 or more.

Proposes a classification of the mental and emotional disorders of children and adolescents from a framework embracing the psychosomatic, developmental, and psychosocial points of view and taking into account the differences between the psychopathologies of children and those of adults.

PUBLIC WELFARE PROJECTED. American Public Welfare Association, 1313 East 60th Street, Chicago, Ill. 60637. July 1966. 206 pp. \$2.75.

Contains 23 papers from the 1965 biennial conference of the American Public Welfare Association, including

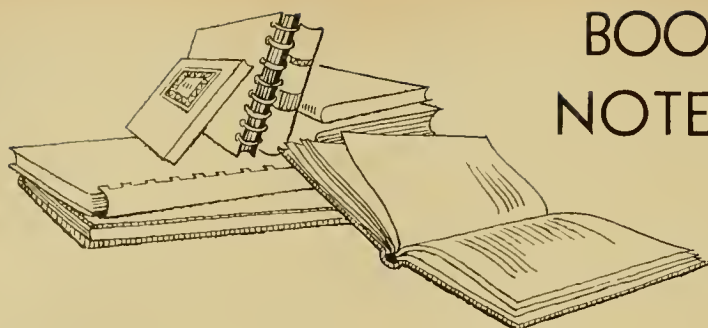
papers on the future shape and goals of public welfare programs and problems of educating and deploying staff.

MANPOWER IN SOCIAL WELFARE: research perspectives. Report of the Institute on Research Approaches to Manpower Problems in Social Welfare Services to Children and Families, held at the University of Minnesota, August 23-26, 1964, with support from the Children's Bureau. Edward E. Schwartz, editor, National Association of Social Workers, 2 Park Avenue, New York, N.Y. 10016. 1966. 160 pp. \$3.

The 10 institute papers, grouped under 4 headings—trends and projections, the welfare system, the professional system, and career choice and education—are followed by a condensation of the discussion under the title, "A Strategy of Research on the Manpower Problem."

THE COMSTAC REPORT: standards for strengthened services. Edited by Frances A. Koestler. Commission on Standards and Accreditation of Services for the Blind, 15 West 16th Street, New York, N.Y. 10011. 1966. 393 pp. \$3, paperback; \$6 clothbound.

Contains recommended standards for administration and service programs for agencies serving blind and visually handicapped persons.



BOOK NOTES

COMPENSATORY EDUCATION FOR THE DISADVANTAGED: programs and practices; preschool through college. Edmund W. Gordon and Dorey A. Wilkerson. College Entrance Examination Board, Princeton, N.J. 1966. 299 pp. \$4.50.

A comprehensive report on Federal, State, and local programs in compensatory education for disadvantaged children, this book surveys dozens of projects, including Project Headstart and Upward Bound, and comments on some aspects of their probable effectiveness. For example, one chapter reports on a survey of compensatory programs in progress at colleges and universities; another describes programs in progress at all levels of education. The book concludes with a directory of compensatory practices and a listing of programs by State and region.

In evaluating the programs, the authors, both on the faculty of Yeshiva University, maintain that teaching disadvantaged children is a special task and cannot be left "to the newest teachers . . . nor to the older teachers, 'left over' in the center-city schools. . . ." They also maintain that many of the programs they surveyed were designed without systematic study of ends and means, despite the seriousness of the problems of educating children and young people from disadvantaged backgrounds.

THE DISADVANTAGED CHILD: issues and innovations. Edited by Joe L. Frost and Glenn R. Hawkes. Houghton Mifflin Company, Boston, Mass. 1966. 445 pp. \$4.95.

The characteristics of deprived children and of the education they receive are the central theme of the 37 articles

carried in this book. For the most part reprints from periodicals and other publications, the articles are presented under eight heads: who the disadvantaged are; characteristics of the disadvantaged; intelligence and IQ; education and the young child; education and the older child; teaching communicative and problem-solving skills; training teachers of the disadvantaged; and the individual, family, and community. The book concludes with a bibliography of books, monographs, periodicals, and research studies on the subject of educating the disadvantaged child.

Contributors include Robert J. Havighurst, Frank Riessman, Jerome S. Brunner, Martin Deutsch, and Helen Heffernan.

LEARNING AND ITS DISORDERS: clinical approaches to problems of childhood, volume 1. Edited by I. N. Berlin, M.D., and S. A. Szurek, M.D. Science and Behavior Books, Inc., Palo Alto, Calif. 1966. 295 pp. \$5.95.

The two psychiatrists who are the editors of this collection of 28 papers on learning and its disorders have brought together material they report they have found useful in teaching. Dr. Berlin is the author of 12 of the papers; Dr. Szurek, of one, and the coauthor of another. The papers are grouped under six general subjects: the beginning of learning and its distortions; the teacher's role and problems; community psychiatry and the schools; antisocial behavior as failure and distortion in learning; learning as a therapeutic tool in antidelinquency projects; and therapeutic efforts in learning disturbances.

In his introduction to the collection, Fritz Redl says: "The editors . . . are

among the few people thoroughly grounded in psychiatric lore, exceptionally experienced in clinical practice, and at the same time respectful of and conversant with the real life problems of both the child learner and the classroom teacher. It is this aspect which makes the volume unique."

CONSTANCY AND IQ CHANGE: a clinical view of relationships between tested intelligence and personality. Alice E. Moriarity, Charles C. Thomas, Springfield, Ill. 1966. 223 pp. \$8.50.

IQ test scores from infancy to prepuberty may reflect "dynamic interactions between an individual child and his environment," according to this book written by an associate of the Menninger Foundation. She bases her conclusion on a study of 65 children of normal intelligence who were tested and whose behavior was observed over a period of 12 years during four phases of their lives—infancy, preschool age, latency, and prepuberty.

The changes in IQ scores indicate that intellectual functioning develops in the children in four ways—constantly, by accelerated spurts, slowly or erratically—the author reports. Constant development characterizes children who were inclined to restrict themselves; acceleration by spurts characterizes children with high achievement drives; slowness characterizes children who were emotionally dependent; and fluctuating development characterizes children highly vulnerable to the stress of environment.

The author concludes that such an analysis of constancy and change in the IQ's of children could "broaden the usefulness of tests" and could throw "new light on the old controversy about constancy of IQ."

DEMON IN MY VIEW. Arthur Henley. Trident Press, New York. 1966. 181 pp. \$4.95.

Following a semibiographical method, this book describes the work of Adelfo Giuseppe Ambrunano Pasquale Antonio Montanari—better known as Monty—the founder-director of a residential treatment center for highly disturbed children in Florida used from time to time by private and public agencies alike. The author points out that many of the children the center has treated successfully seemed to be hope

ess cases—for example, a girl who thought she was a dog, a boy who could not resist stealing Cadillacs, and a girl who thought a man was speaking in her head.

In the center, the author reports, a group of psychiatrists, psychologists, and social workers sets up the diagnostic and treatment plan for each child, pivoted on individual treatment. He attributes much of the center's success to the strong, personal involvement of the founder-director and his willingness and that of his staff to use unorthodox methods when necessary.

DYNAMICS OF DEVELOPMENT: euthenic pediatrics. Dorothy V. Whipple, M.D. McGraw-Hill Book Co., New York, 1966. 648 pp. \$15.

This volume offers pediatricians and other professional men and women working with children "a philosophic background and a point of view for understanding what makes children sick," rather than a practical guide to pediatrics, according to its author, a clinical associate professor of pediatrics at Georgetown University School of Medicine.

With an emphasis on well-child supervision, the book discusses both the physical psychological aspects of growth and development in children from heredity and intrauterine life through adolescence. Its chapters are grouped under the following topics: The scope of pediatrics; the beginnings; the increment in pounds and inches; the development of organic structure; life patterns of sleep and nutrition; the development of behavior; horizontal pictures; and sociological considerations in relation to the family.

JUVENILE DELINQUENCY: a book of readings. Rose Giallombardo, editor. John Wiley & Sons, New York, 1966. 565 pp. \$8.95.

This textbook, according to the editor, "is designed to introduce the student of juvenile delinquency to . . . important contemporary literature in the field." It contains selections from journals, books, and monographs that treat juvenile delinquency from a sociological viewpoint, either by reporting the results of research or by providing theoretical analyses and description. The readings are grouped under five sections: The data of delinquency; prob-

lems of definition and measurement; development of delinquent behavior; the empirical structure of delinquent groups; legal processing of delinquency; and treatment and prevention.

STUDIES OF TROUBLESOME CHILDREN. D. H. Stett. Humanities Press, New York, 1966. 208 pp. \$5.50.

Deviant behavior in children may be caused by a greater than normal susceptibility to stress because of "congenital impairment" (the result of something that happened before or at birth) rather than by an unfavorable environment, the author of this book maintains. In evidence, he describes several studies of disturbed children made in Great Britain, including one on 300 truants, that points to a "consistent congenital factor" beneath deviant behavior.

Congenital damage tends to cumulate, the author also maintains. The child who suffers from "one form of somatic-neural impairment" is likely to suffer from a second; if from two, then from a third, and "so on . . . until the point of nonviability is reached," he points out in an hypothesis he calls the "law of multiple congenital impairment."

In discussing the "law" in relation to diagnosis, prevention, and treatment, the author says that it applies particularly to the selection of children prone to delinquency and to treatment for them by casework.

The author also describes a program to prevent maladjustment to school, which he has designed on the basis of a mental health service for children.

In his final chapter, the author explains his general view of human motivation, on which his law of multiple congenital impairment is based.

HOMEMAKING FOR THE HANDICAPPED: a resource book in home management for the physically handicapped and their families and for professional personnel concerned with rehabilitation. Elizabeth Eckhardt May, Neva R. Waggoner, and Eleanor M. Boettke. Dodd, Mead & Co., New York, 1966. 206 pp. \$7.50.

Although 12 percent of the more than 40 million Americans (mostly women) who keep house are physically handicapped, homemaking "continues to be

the most neglected area of rehabilitation," according to the authors of this book, which aims at supplying a guide to the handicapped homemaker, her family, and the rehabilitation worker.

The book explores management principles used by women with physical disabilities; ways to simplify tasks in the care of children and play activities handicapped mothers can supervise; selection and adaptation of clothing for handicapped persons; devices, tools, and methods that save energy and time; and the adaptation of equipment for child care and housekeeping.

INSTITUTIONS ARE PEOPLE: a documentary of life in a State school for the mentally retarded. E. Charles Bauer. The John Day Co., New York, 1966. 156 pp. \$1.50.

By describing his work as a chaplain for 7 years at a State school for the mentally retarded, the author of this book gives a picture of life in an institution for patients and staff members alike. Though puzzled at first by what he could do to serve the patients, in time he learned to "help fight the war against mental retardation as a member of the training and treatment team." He points out that, although there is much room for improvement, the institution at which he served is operated by many devoted and skillful people.

TEACHING DISADVANTAGED CHILDREN IN THE PRESCHOOL. Carl Bereiter and Siegfried Engelmann. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1966. 312 pp. \$7.95.

To help the disadvantaged child enter first grade on a footing with other children, the authors of this book have devised a program based on the assumption that preschool education must meet definite, day-to-day goals and that direct control over the pupil's progress is necessary. Much of this book is given to a description of their plan.

Because they believe that cultural deprivation stems largely from language deprivation, the authors point out that their plan centers on strongly structured courses in language. By overcoming language handicaps, they maintain, the disadvantaged child can overcome many other handicaps. In support of their method, the authors summarize the results of an experiment they conducted

using it with a group of severely deprived 4-year-old children who were brought up to the second-grade level in arithmetic and to the first-grade level in reading in 9 months' time.

CHILDREN IN CARE—AND AFTER: a study of a group of Glasgow children who came into the care of the local authority. Thomas Ferguson. Oxford University Press, New York. 1966. 139 pp. \$2.40.

Four out of 5 of over 200 young people who had been brought into public care and "boarded out" with foster parents, placed with relatives (not parents), or placed in a children's home were found to have reasonably good prospects 2 years after they had "passed

out" of care at 18, according to this report on a study made recently in Scotland.

The author reports that at the time of the study these young people were employed at about the same rate as other young people in the general population but that the jobs they held usually required less skill. However, he also found that based on IQ scores these young people performed at about the same level as young people from normal homes who left school at the earliest age permitted.

He also reports that about 5 percent of the young men have been convicted of breaking the law and that about 11 percent of the young women have had children out of wedlock (several before reaching 18), a slightly higher percent

on both counts than in the general population. On the whole, he found them immature, particularly socially.

EMERGING CONCEPTUAL FRAMEWORKS IN FAMILY ANALYSIS Edited by F. Ivan Nye and Felix M Berardo. The Macmillan Co., New York. 1966. 328 pp. \$7.95.

This book deals with theories about the family and approaches to research on the family. The 11 papers that comprise it consider the family from the point of view of anthropology; structure and function; institutional, interactional, and situational approaches; psychoanalysis; social psychology; developmental theory; economics; law and religion and philosophy.

films on child life

Charges for rental or purchase may be obtained from distributors.

"M.R." 60 minutes; sound; color; rent or purchase.

Depicts the interacting roles of many professional and nonprofessional persons in behalf of retarded children, including the contribution of physicians and others in a State crippled children's program.

Audience: Professional and lay persons concerned with mental retardation.

Produced by: Bureau for Handicapped Children, Wisconsin State Department of Public Information; and the University of Wisconsin.

Distributed by: Bureau of Audio-Visual Instruction, University of Wisconsin, 1312 West Johnson Street, Madison, Wis. 53702.

HER NAME WAS ELLIE, HIS NAME WAS LYLE. 29 minutes; sound; black and white; purchase.

Tells the story of a high school boy infected with syphilis who is unaware of the services available for treatment. Stressing both the physical and emotional consequences of promiscuity, it

describes the infectious nature and points out the importance of early treatment. It also portrays the role of the physician and public health department in treating venereal disease and in tracking down the sources of infection.

Audience: Youth groups and junior and senior high school students, with a physician, nurse, or other trained discussant.

Produced by: Louis DeRochemont Associates, for the Bureau of Public Health Education, New York City Department of Health.

Distributed by: Louis DeRochemont Associates, 18 East 48th Street, New York, N.Y. 10017.

BOY TO MAN. 16 minutes; **GIRL TO WOMAN.** 18 minutes; sound; color; purchase.

Stressing the normality of individual differences in the rates of physical growth and sexual maturation between boys of the same age and girls of the same age, these films explain simply the physiological manifestations of maturation in adolescent boys; the male and

female reproductive functions, and the relation of secondary sexual changes to glandular and primary sexual changes. They employ basic scientific terms which are enunciated and also presented in written form on the screen.

Audience: Junior high school boys and girls; parents; and science, physical education, and health education instructors.

Produced by: Churchill-Wexler Films
Distributed by: Henk Newenhouse Inc., 614 Davis Street, Evanston, Ill. 60201.

THE LOSERS. 31 minutes; sound black and white; rent or purchase.

Aimed at making young people more aware of the damage caused by the use of drugs, this film looks into an investigation of the prevalence of experimentation and the habitual use of pep pills, goof balls, heroin, and marijuana and the practice of glue-sniffing among young people 12 to 21 years of age. The harmful effects of such practices are shown, and recounts of actual experiences by young people from slums and middle-class neighborhoods are presented.

Audience: Youth classes in health education; teachers; guidance counselors; doctors; psychologists; sociologists; and PTA groups.

Produced by: WCBS-TV, New York
Distributed by: Carousel Films, Inc. 1501 Broadway, New York, N.Y. 10086.

HERE and THERE



Child labor

Between July 1, 1965, and June 30, 1966, nearly 18,500 children were employed in violation of the child labor provisions of the Fair Labor Standards Act, according to figures compiled by the U.S. Department of Labor, Wage and Hour Public Contracts Division. The law prohibits the employment in interstate commerce or in the production of goods for interstate commerce of children under 16 years of age during school hours, of children under 18 in hazardous occupations at any time, and of children under 14 in any occupation at any time. While minors 14 and 15 years of age may be employed outside school hours in nonmanufacturing and non-mining occupations, regulations regarding hours of work and other specific conditions must be complied with.

The law also prohibits the employment of children under 16 in interstate agriculture during school hours, except by their own parents on home farms. (Before February 1, 1967, the minimum age for such employment was 14.) However, children of any age may work in agriculture outside school hours unless they are in occupations declared hazardous by the Secretary of Labor.

Violations of the act were found in 1,725 of the 2,880 farms investigated by the Department. Nearly 5,500 of the children whose employment was in violation of the act were children under 16 working in agriculture during school hours. About 18 percent were 9 years old or younger; about 52 percent were 10 through 13. The total includes nearly 1,300 migrant children.

Over half of the 12,979 children employed in violation of the law in non-agricultural occupations were in hazardous occupations, most often as drivers of or helpers on motor vehicles.

Some were employed in violation of more than one of the 17 hazardous occupations orders issued by the Secretary of Labor. Approximately 41 percent of the minors found illegally employed in nonagricultural occupations were under 16 years of age. Children ranging in age from 5 to 15 years were employed often in occupations so hazardous that an 18-year minimum age applied, or were working excessive hours or in manufacturing occupations.

Refugee children

As of December 31, 1966, only 395 Cuban refugee children were still in foster care under the United States Cuban refugee program, the lowest number since the initiation of the program in 1961 (see "Cuban Children Away From Home," by Kathryn Close, *CHILDREN*, January-February 1963). Thus, more than 8,200 of the 8,600 Cuban children who have arrived in this country without their parents or designated guardian in the past 6 years have been reunited with their parents in this country or elsewhere or have passed the age of 19 and are no longer eligible for care under the program. Of these, 1,032 were discharged from the program during 1966 to newly arrived parents, most of whom came from Cuba by the United States Cuban refugee airlift. The airlift, which began in December 1965, operates 10 planes a week from Cuba to Miami.

For youth

The need for early planning of summer programs for adolescents was underscored in an all-day meeting held in Washington, D.C., on January 18 under the sponsorship of the Children's Bureau. The 32 participants repre-

sented 21 national voluntary organizations and 5 units of the Federal Government. The purpose was to find ways in which the Federal Government and the voluntary agencies could work together to provide young people with opportunities for satisfying and creative leisure-time activities during their summer vacations.

The participants reported that the stimulus of the Federal Government's interest in 1966—sparked by a task force created by the President—had indeed resulted in many more, and a great diversity of, opportunities being provided young people during that summer than in the previous summer. Their agencies had, for example, not only expanded their regular camping, sports, and club programs, but had also provided many new opportunities for young people to have adventure, to serve their communities, and to explore possible careers. However, they frankly discussed some of the obstacles to the maximum use of resources they had encountered and most frequently named late planning and fragmentation of effort. Representatives of voluntary agencies especially stressed the importance to achieving greater effectiveness in 1967 of their knowing well in advance of the summer what would be expected of them and what financial resources would be available to them through what government agencies.

The Children's Bureau accepted responsibility for finding out what summer projects are being planned by other Federal agencies and for keeping the national voluntary agencies informed as plans develop.

Sex education

Approximately 75 professional people met together in Washington, D.C., for 2½ days in early December at the invitation of the Sex Information and Education Council of the United States (SIECUS) to discuss and plan for the education of young people and adults in matters of sex. The conference was made possible by a grant from the Office of Education.

The focus of the conference was on the preparation of an interdisciplinary book of readings on sex education for teachers in training, but the discussions ranged far beyond the bounds of this topic.

Most of the working groups stressed

the necessity of helping society at large as well as young people acquire social values and a philosophy about sex that can serve both society and the individual. The discussions underscored the importance to the community of sex education for young people and the responsibility of many social institutions for providing it.

Parent education was considered as central to any and all sex education that takes place in the home. Participants maintained that the most fundamental element in the sex education of children is the relationship between parents, and that parents, therefore, need to know what their own values are and to be able to convey them to their children in the course of day-to-day living. The responsibility of the school from preschool through high school was emphasized. Major obstacles to meeting this responsibility were identified as a dearth of educational materials and a scarcity of teachers to carry out sex education adequately.

The need for more research was also stressed, especially in relation to the current sexual behavior of adolescents and young adults.

Among the opportunities for leadership training in sex education being offered in the summer of 1967 are the following:

- A 6-week institute, June 26–August 4, at the University of Connecticut entitled, "The Family Life Institute With Emphasis on Sex Education," and directed to persons at the graduate level of study. Sponsored by the university's department of child development and family relations with the help of the G. D. Searle Reference and Resource Program, it will be conducted by specialists in family life education from both inside and outside the university. The fee for the institute is \$95; enrollment is limited to 60. For further information inquire of Eleonore B. Luckey, Department of Child Development and Family Relations, University of Connecticut, Storrs, Conn. 06268.

- A 1-week workshop at the University of Oregon, June 12–17, for 40 adults—teachers in secondary schools, guidance counselors, social workers—and 40 young persons of teen age, sponsored by the department of health education. The fee for the adults is \$28. The young people, who are to be recruited

from local high schools to represent a kind of "laboratory" for the adults, will be provided scholarships. Inquire of Robert E. Kime, Department of Health Education, University of Oregon, Eugene, Oreg. 97403.

- Two 1-week institutes, June 19–30 and August 7–11, at the University of California at Davis, sponsored by the extension division, the first for both adults and young people (30 each) as in the Oregon institute, the second for teachers of family living courses. The fee is about \$45. Inquire of Lura Middleton, Extension Division, University of California, Davis, Calif. 95616.

Child abuse

Warnings against "abusing the parents" of children who are victims of parental abuse and so aggravating the abuse of the child were repeatedly given in the Governor's Conference on Child Abuse held in Raleigh, N.C., November 22, 1966. Called by the Governor to focus public attention on the problem of child abuse, the conference was sponsored by the North Carolina Health Council; the North Carolina Council on Mental Retardation; the State Department of Public Instruction, Public Welfare, and Mental Health; and the State Board of Health. It was made possible by a grant from the Alfred I. DuPont Institute of the Nemours Foundation. The more than 650 participants included physicians, social workers, health workers, police officials, juvenile court officials, school administrators, and teachers.

Speakers at the conference discussed the social, medical, and cultural aspects of child abuse and the roles of social work, medicine, the courts, and education in meeting the problem. They emphasized the need for skillful people to handle the problem.

Proceedings of the conference are available from the North Carolina State Board of Health, Maternal and Child Health Section, Raleigh, N.C. 27602.

Toward coordination

The Department of Health, Education, and Welfare (DHEW) recently set up a new center for community planning in the Office of the Secretary to work closely with the Department of Housing and Urban Development (DHUD) on programs aimed at solving

the problems of cities. Besides acting as the liaison office with DHUD for DHEW, the center reviews proposals for model city projects and provides technical assistance to DHUD on the needs of cities in relation to health, education, and welfare. The center also coordinates the activities of DHEW constituent agencies concerning model city projects in providing technical planning services to city and State governments and local agencies.

The American Public Welfare Association (APWA) is launching a 3-year project under a grant from the Office of Economic Opportunity (OEO) to provide technical assistance to public welfare departments and local community action programs to stimulate a relationship between them for the purpose of strengthening public welfare programs.

Still in the explorative stage, the project has a tentative list of priorities for consideration with public welfare officials. These include: (1) Development of "structured" services focusing on specified purpose, product, or results; (2) methods of communicating with public assistance recipients and with the organized poor; (3) aspects of administration of financial aid affecting equity and incentive; (4) opportunities for employment and achievement of the poor in the public welfare establishment; (5) the role of the poor and community action groups in public welfare policymaking and planning; and (6) the role of public welfare agencies in developing better housing.

The project will operate under the direction of a small headquarters staff and advisory committee. Its director is John M. Wedemeyer, formerly director of the California State Department of Social Welfare.

Unmarried mothers

As part of the Children's Bureau maternal and infant care project in Chicago, the Florence Crittenton Association of America, Inc., has recently established the Crittenton Comprehensive Care Center to administer the expanded program of comprehensive medical, mental health, and social service project for adolescent unmarried mothers and fathers that grew out of the Community Services Project, a 3-year demonstration project initiated by

the mental health division of the Chicago Board of Health. (See "Comprehensive Services for Adolescent Unwed Mothers," by Mattie K. Wright, *CHILDREN*, September-October 1966.) Operating under an agreement between the Chicago Board of Health, the Illinois State Department of Public Health, and the Florence Crittenton Association of America, Inc., with the Children's Bureau's financial support, the center is building up a staff of health educators, psychologists, social workers, nurses, nutritionists, obstetricians, and other health specialists. It is expected to serve from 1,200 to 1,500 adolescent unmarried mothers and their families annually, including, whenever possible, the fathers of their children. Mrs. Wright, former director of the Community Services Project, is its director.

The new center works closely with the Chicago Board of Education and refers pregnant girls who are willing and able to continue their schooling to the board's family living center, established last fall to make this possible.

Research on children

Seven research studies in child development and child welfare have been initiated in Great Britain by the National Bureau for Co-operation in Child-Care since its formation 3 years ago by British voluntary organizations and professional associations concerned with the welfare of children.

The bureau has a fourfold purpose: to make existing knowledge of children's development, needs, and problems more readily available; to improve lines of communication between the disciplines and the statutory and voluntary services; to explore the possibilities of making better use of existing services and to encourage the development of new ones; and to help bring a preventive outlook into the field of child care. It works through a staff headed by psychologist M. L. Kellmer Pringle, which carries out the research projects, and through local and area "groups"—open to persons engaged in health, education, or welfare services to children—which meet regularly to discuss the needs of children.

Through an arrangement with a commercial publisher (Longmans, London), the first three of the bureau's research reports were published in 1966: "Four Years On," a followup study at age

PRESIDENT'S MESSAGE ON THE WELFARE OF CHILDREN

Pointing out that as long ago as 1912 when the Federal Children's Bureau was established "Congress had pledged its power to the care and protection of America's young people," President Lyndon B. Johnson sent the Congress a Message on the Welfare of Children on February 8, 1967 embodying a 12-point program for broadening the Nation's activities for the health and welfare of children. In his message, the President referred to studies which indicate that ignorance, ill health, and personality disorder are "disabilities often contracted in childhood; afflictions which linger to cripple the man and damage the next generation." Maintaining that "our goal must be clear—to give every child the chance to fulfill his promise," the President recommended measures to—

"1. Preserve the hope and opportunity of Headstart by a 'Follow-Through' program in the early grades.

"2. Strengthen Headstart by extending its reach to younger children.

"3. Begin a pilot lunch program to reach preschool children who now lack proper nourishment.

"4. Create child and parent centers in areas of acute poverty to provide modern and comprehensive family and child development services.

"5. Help the States train specialists—now in critically short supply—to deal with problems of children and youth.

"6. Strengthen and modernize programs providing aid for children in poor families.

"7. Increase social security payments for 3 million children, whose support has been cut off by the death, disability, or retirement of their parents.

"8. Expand our programs for early diagnosis and treatment of children with handicaps.

"9. Carry forward our attack on mental retardation, which afflicts more than 125,000 children each year.

"10. Launch a new pilot program of dental care for children.

"11. Help States and communities across the Nation plan and operate programs to prevent juvenile delinquents from becoming adult delinquents.

"12. Enrich the summer months for needy boys and girls."

15 of children whose development had been followed between the ages of 7 and 11 when they were attending two different types of junior schools—traditional and progressive; "11,000 Seven-Year-Olds," the first report of a longitudinal study of children born in 1958 concerned with their abilities, progress, behavior, and health in relation to environmental factors; and "Adoption—Facts and Fallacies," a review of research relating to adoption in the United States, Canada, and Great Britain between 1948 and 1965.

Other studies still in progress are a longitudinal study of junior school children, a pilot study of family advice services, a national study of children in

foster care, a national study of "word-blind" children, and a study of educational and employment opportunities for young people with multiple handicaps.

Child care

Intensive casework with children in foster care and instruction in homemaking for families helped end or prevent the need for foster care for many of the more than 400 children served by a 3-year, two-part project operated by the Santa Clara County Welfare Department in California between 1962 and 1965, for families receiving assistance under the aid to families with de-

pendent children program, according to the project's report. Through the project, the county welfare department offered intensive casework to families of 137 children in foster care and instruction in child rearing, money and household management, health care, and parent-child relationships to 59 families with 299 children. All families either had children in foster care or were faced with the possibility of placing a child in foster care. Most had only one parent.

In drawing their conclusions, project workers pointed out that nearly half of the 137 children for whom intensive casework services had been provided had been taken out of foster care by the end of the project. Twenty-nine had been reunited with their parents, 38 had been adopted, and 4 were awaiting adoption. The service was provided by professionally trained caseworkers with special skill in working with children and their families.

Only 13 children of the 59 families involved in the homemaker part of the project were in foster care at the end of the 3 years.

The Utah State Department of Welfare recently authorized the 20 nonprofit day-care and training centers for retarded and handicapped children receiving State financial support to add trained social workers to their staffs and agreed to pay 80 percent of the workers' salaries. Three centers have already employed social workers.

The centers are located in urban and rural areas throughout the State. The first was set up in 1956 by the parents of the children who were later enrolled, professional men and women, and others interested in the welfare of mentally retarded and handicapped children. In 1959 the State began giving support to the centers, at first through demonstration grants. The centers are now supported by tuition fees, community contributions, and State funds. The 20th center opened last January.

Education

Early in January the Office of Education issued its desegregation guidelines to the States for the school year 1967-68. In an accompanying letter, Commissioner of Education Harold E. Howe pointed out that these are virtu-

ally the same as those issued for 1966-67. The one substantive change affects only school districts operating under a "freedom of choice plan." In the school year 1967-68, these districts will have more time in which to choose the 30-day period during which students may designate the schools they prefer to attend.

To alert high school students who will graduate this year to the Federal programs of financial assistance offered to college and vocational school students, the Office of Education early this year sent out a packet of material on such programs to every high school, college financial aid office, and library in the Nation, to American schools overseas, and to persons working with young people such as the directors of Upward Bound programs.

Single copies of the packet are available from the Bureau of Higher Education, Office of Education, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20202.

Family planning

The New York State Department of Social Welfare recently ruled that caseworkers employed by local public welfare departments may introduce the subject of birth control to persons in their caseloads, when advisable. The department had previously ruled that caseworkers could not bring up the subject, though they could furnish information about where to go for contraceptive service if the client requested it. Under the new ruling, women who show interest in birth control after being advised that such a service is available will be referred to an appropriate health agency. The welfare department will continue to pay for materials and medications as "directed or prescribed with reference to family planning" for clients of welfare departments.

Anticipating a recommendation by the population study commission appointed by the Governor of California in August 1966, the California State Department of Public Health, at the request of the California Conference of Local Health Officers, adopted a regulation on December 2, 1966, making the provision of family planning services by local health departments a requirement

for eligibility for State subsidy. The commission, which had been appointed to review and prescribe State and local activities "to increase freedom of choice in family planning," submitted its report on December 20. Among other recommendations, it urged that—

- Family planning services be provided in a way that would insure comprehensiveness in personal health care.
- Family planning services include genetic counseling and fertility service in addition to contraceptive advice and service.
- Welfare departments assume responsibility for assisting clients in acquiring a better understanding of the problems related to family size and for referring those interested in family planning to appropriate services.
- Information about family planning be included in welfare department in-service training programs.
- Information about family planning services be included in the referral services of the State's multiservice centers.
- Medical education include content about genetic counseling, the effect of family composition on health, and methods of family planning.
- A public information program be developed to promote the idea that every child should be a "wanted" child

Miscellaneous

On January 1, 1967, the former International Conference on Social Work (ICSW) became the International Council on Social Welfare, with a revised constitution and its first full-time secretariat. Ruth M. Williams, who was director of the New York office of the National Conference on Social Welfare and half-time executive officer of the International Conference for 16 years, has become the first full-time secretary general of the Council. Headquarters for ICSW remain at the old address—345 East 46th Street, New York, N.Y. 10017.

The revised constitution for ICSW identifies four principal functions: (1) To provide a worldwide forum for the discussion of issues in social welfare; (2) to foster the development of social welfare throughout the world; (3) to promote the exchange of information among social workers and social agencies; and (4) to promote cooperation among international organizations concerned with social welfare.

READERS' EXCHANGE

AMBINDER and FALIK: *Collaborative consultation*

In their article "Keeping Emotionally Disturbed Foster Children in School" CHILDREN, November-December 1966), Walter J. Ambinder and Louis H. Falik of the Detroit Foster Homes Project graphically illustrated not only natural difficulties encountered by a foster care agency when it attempts to intervene in a public school's methods of dealing with a foster child, but also certain problems that might have been modified or avoided under a mode of operation sensitive to the structure of public school organization.

When a mental health agency attempts such intervention in behalf of any emotionally disturbed child, often it does not seem aware of certain facts: (1) That authority in public schools proceeds in a direct line from superintendent to principal to classroom teacher; (2) that school systems need a variety of educational settings so that placing a disturbed child in public school the limits of a particular school to tolerate his behavior may be assessed in relation to the training and the personality of the teacher, the number of pupils in each class, or the availability of special classes; (3) that each case needs a realistic estimate of the potential of the disturbed child to function in a normal school setting" based on such factors as his tolerance to frustration, his degree of impulse control, and the nature of his aggressive drives; (4) that a severely disturbed child sometimes needs a brief period of complete release from school demands, followed by school attendance in brief but gradually lengthened sessions.

Over the past 3 years, the Merrifield center project in Worcester, Mass., with support from the National Institute of Mental Health, has provided residential treatment for severely emotionally disturbed children in foster care. In working with public schools,

the center's staff has sought to promote collaborative consultation with the school to keep severely disturbed children in regular classes in public schools. This involves a continuous interpersonal process based on the following conditions: (1) Recognition by both school and agency of the differential roles of educators and clinicians; (2) development of attitudes of mutual trust and respect so that a workable atmosphere is established in which representatives of diverse disciplines can discuss learning and behavior difficulties of disturbed children; (3) continuing efforts by agency personnel to maintain rapport with educators even when the latter exhibit defensive behavior, ambivalence, or resistance; (4) retention by the school of independence in decisionmaking in regard to school matters; and (5) assumption by the agency of responsibility to interpret school decisions to the foster parents.

Mary E. Farragher
Therapeutic Educator
Merrifield Center
Worcester, Mass.

EISENSTEIN: *An oversight*

I note with interest the four objectives of the health program discussed by Fannie Eisenstein in the November-December 1966 issue of CHILDREN ("A Health Service Program for Children in Day Care") and wonder how she could overlook as important an aspect of child health as good hearing. She does not mention any planning to include a check of the children's hearing or parent guidance to prevent hearing loss.

More lives are handicapped by poor hearing than by almost any other physical disability. National statistics indicate that about 7 percent of children entering school have hearing trouble. Of these, over half can be successfully treated by medical procedures. Three percent of these children have perma-

nent hearing impairments, many of which could have been prevented.

Any health program for preschool-age children is seriously inadequate if emphasis is not put on hearing examinations and prevention of hearing loss.

C. E. Torrence

Director of Hearing and Speech
Services, St. Louis Hearing
and Speech Center, St. Louis, Mo.

Author's reply

The point Mr. Torrence makes about hearing is well taken. We attempted to locate screening and preventive programs and found none available for a universal, group application. We, therefore, were limited to the ongoing observation of teachers, parent education, and the agonizing search for direct service on an individual basis in an area which lacked both programs and persons qualified to provide the needed service.

Fannie Eisenstein

for parents

TODAY'S TEENAGERS. Evelyn Mills Duvall. Association Press, 291 Broadway, New York, N.Y. 10007. 1966. 256 pp. \$4.95.

THE FIRST BIG STEP: A handbook for parents whose child will soon enter school. National School Public Relations Association, National Education Association, 1201 16th Street NW., Washington, D.C. 20036. 1966. 34 pp. 60 cents.

HOW TO HELP YOUR CHILD IN SCHOOL. Robert Sunley. Public Affairs Committee, 351 Park Avenue South, New York, N.Y. 10016. Public Affairs Pamphlet No. 351. November 1965. 20 pp. 25 cents.

SEX EDUCATION IN THE FAMILY. Francis L. Filas. Prentice-Hall, Inc., Englewood Cliffs, N.J. 07632. 1966. 112 pp. \$3.95.

MOST OF US ARE MAINLY MOTHERS. Carol Bartholomew. The Macmillan Company, 60 Fifth Avenue, New York, N.Y. 10011. 1966. 203 pp. \$4.95.

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

DIALOGUE ON ADOLESCENCE. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 442. 1967. 30 pp. 30 cents.

Presents the highlights of a 1-day meeting on problems facing youth today attended by the 14 members of an ad hoc committee on cooperative planning for youth appointed by the Children's Bureau.

REPORT ON FAMILY PLANNING: activities of the U.S. Department of Health, Education, and Welfare in family planning, fertility, sterility, and population dynamics. Department of Health, Education, and Welfare, Office of the Secretary. September 1966. 35 pp. 25 cents.

The first in a series of annual reports summarizing the family planning activities of the Department.

MENTAL RETARDATION GRANTS: fiscal year 1966. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Individual and Family Services, The Secretary's Committee on Mental Retardation. September 1966. 139 pp. 70 cents.

Lists, by State, the grants awarded in the field of mental retardation—for research and demonstration, training, construction, and others—by the agencies of the Department of Health, Education, and Welfare.

PROS AND CONS: NEW ROLES FOR NONPROFESSIONALS IN CORRECTIONS. Judith G. Benjamin, Marcia K. Freedman, and Edith F. Lynton. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. 1966. 127 pp. 40 cents.

This publication describes some current experiments in the use of nonprofessional personnel, including inmates, in rehabilitative efforts in correctional institutions, and in probation and

parole work. It concludes with guidelines for introducing nonprofessionals into agency programs, including suggested career line models.

OBESITY AND HEALTH: a source book of current information for professional health personnel. Department of Health, Education, and Welfare, Public Health Service, Division of Chronic Diseases, Heart Disease Control Program. 1966. 77 pp. 60 cents.

Directed to the health professions, this publication reviews the findings of recent research on obesity, its association with other health problems, and methods of weight reduction.

EDUCATING DISADVANTAGED CHILDREN UNDER SIX; EDUCATING DISADVANTAGED CHILDREN IN THE PRIMARY YEARS; EDUCATING DISADVANTAGED CHILDREN IN THE MIDDLE GRADES; ADMINISTRATION OF SCHOOL PROGRAMS FOR DISADVANTAGED CHILDREN. Helen K. Mackintosh, Lillian Gore, and Gertrude M. Lewis. **EDUCATING DISADVANTAGED CHILDREN IN THE ELEMENTARY SCHOOLS:** an annotated bibliography. Gertrude M. Lewis and Esther Murow. Department of Health, Education, and Welfare, Office of Education. Disadvantaged Children Series Nos. 1 through 5. 1966. 26 pp., 15 cents; 52 pp., 25 cents; 47 pp., 25 cents; 42 pp., 20 cents; 33 pp., 20 cents, respectively.

A series of reports on techniques and practices in various parts of the country in working with educationally disadvantaged children 3 to 11 years old.

SOCIAL DEVELOPMENT: key to the Great Society. Department of Health, Education, and Welfare, Welfare Administration, Division of Research. WA Publication No. 15. 1966. 92 pp. 55 cents.

Through 55 charts and text, this publication presents data showing an im-

balance of social and economic development in the United States. It points out that although the rate of economic growth has been rapid, there have been lags in the development of social welfare programs and services not only for the poor but also for all groups in our population.

LOW-INCOME LIFE STYLES. Loh M. Irelan, editor. Department of Health, Education, and Welfare, Welfare Administration, Division of Research. WA Publication No. 14. 1966. 86 pp. 35 cents.

Five papers summarizing research findings relating to low-income families: general outlook on life, family organization, educational training, health care, and consumer practices.

CHILDREN'S BUREAU ACTIVITIES IN MENTAL RETARDATION. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 14 pp. Single copies free from the Bureau.

Briefly describes the aspects of Children's Bureau programs of health services, child welfare services, and research and demonstration grants that are concerned with mental retardation.

A GUIDE FOR TEACHING POISON PREVENTION IN KINDERGARTENS AND PRIMARY GRADES. Department of Health, Education, and Welfare, Public Health Service, Division of Accident Prevention. PHS Publication No. 1381. Reprinted September 1966. 95 pp. 5 cents.

Offers teachers suggestions for teaching young children ways of safeguarding themselves and the members of their family against accidental poisonings.

DIRECTORY OF PUBLIC TRAINING SCHOOLS SERVING DELINQUENT CHILDREN. Compiled by Kenneth S. Carpenter. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. October 1966. 112 pp. Single copies free from the Bureau.

An eighth revision, this edition lists by State or jurisdiction, 320 State and local training schools, camps, and reception-diagnostic centers that serve delinquent children committed by the

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Growing up and showing the doctor how fast—a familiar scene in a pediatrician's office. "For pediatricians the paramount goal is prevention of illness," says Dr. Robert J. Haggerty, in the leading article in this issue, and he discusses some of the special skills which he believes must be built into pediatric training if this goal is to be accomplished.

children

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Today, the medical profession faces pressing need and an unmatched opportunity to examine and modernize the training of physicians who will be caring for tomorrow's children are receiving. The pressing need comes from the increasingly severe professional manpower shortage and from the growing realization that for many people in this country the breakdown of health begins in early childhood. The opportunity comes from the recent breaches in the economic barrier that for so long have kept good medical care out of the reach of many families and children.

In focusing this article on postgraduate pediatric education, I am assuming that by the time physicians receive their medical degrees they have already learned a good deal about the normal growth and development of children and have developed basic skills needed to obtain data from interviews, physical examinations, and laboratory tests. Postgraduate education should refine such basic skills and add many more.

It seems self-evident that postgraduate training of physicians to meet the medical needs of children should be related to the health problems faced by children today. However, it is sometimes difficult to incorporate this principle into the hospital internship and residency programs through which postgraduate education is obtained. As White and his associates have pointed out, the patients seen in teaching hospitals are a decidedly biased sample of all the sick people in the community.¹ A great many of the health problems of children do not automatically come to the attention of physicians in training in university hospitals.

Children's health problems

Children's health problems are of three general types: (1) conditions that cause death; (2) conditions that cause morbidity, acute and chronic;² and (3) parental anxieties. (Robertson³ has demonstrated that a majority of mothers of newborn babies suffer anxiety about the baby's feeding, breathing, bowel movements, or some other normal function.) The pediatrician in training needs experience with problems of all these types. He also needs experience with the social conditions of the families in which children are reared, for whether or not the child lives in a healthy family or social environment has a great bearing on his present and future health.^{4, 5}

Although pediatricians in training must gain

PEDIATRIC TRAINING

and the MANPOWER PROBLEM

ROBERT J. HAGGERTY, M.D.

knowledge of and experience in the diagnosis and management of children with illnesses serious enough to warrant hospitalization, this is not enough. For pediatricians the paramount goal is prevention of illness; and prevention requires special skills. One important skill is the ability to detect vulnerable groups—the groups of children in the population who are most likely to develop ill health. Because we have yet to identify all such children clearly, it is difficult to teach methods of prevention. However, we have identified some of these groups. They include premature babies, babies born to families having a history of genetic disease, babies of mothers who have had no prenatal care, and children of nonwhite, low-income families in city slums.

Traditionally, hospital-based pediatric training programs have emphasized the diagnosis and management of the acute illnesses that cause morbidity and death and have given less attention to the techniques of primary prevention and early diagnosis of such common and treatable presymptomatic problems as incipient vision and hearing disorders or to the management of complex handicapping conditions such as cerebral palsy or emotional disturbance. They have given even less attention to training pediatricians in the diagnosis and management of the underlying social and family problems that affect illness patterns or to training in methods of seeking out those families in the population who are resistant to medical care though they may have the greatest needs. The morbidity in this hidden group of nonpatients has been likened to the hidden portion of an iceberg—much greater than the part that is seen.⁶

All children need some preventive services, but it

is wasteful to provide those not at great risk the same services needed by those at high risk of developing irreversible impairment. Thus a major task for the pediatric profession in the immediate future is to find out more about who the most vulnerable groups are, how they can be identified, what to do about them when they have been identified, and how to provide the kind of setting for physicians in training that will stimulate them to develop these skills.

Some valuable experience in ways to approach this task is now being gained in universities with maternity and infant care and children and youth projects supported by the Children's Bureau. For example, in the family continuity program at the University of Rochester, pediatric residents are now learning skills needed to care for "high-risk" children in low-income areas.

Continuity of care

Many teachers of pediatrics believe that the first goal of postgraduate training is to provide the physician with enough experience in diagnosing and treating the common serious and acute illnesses of children to make him thoroughly competent and comfortable in managing them. I do not deny the importance of this traditional aspect of pediatric care, nor do I suggest that training time spent on specific diseases should be in proportion to their frequency. But I do feel it important to emphasize certain additional aspects that in many places do not receive enough emphasis today.

With a good basic medical school education, the

pediatrician in training in most university hospitals and the larger community hospitals can develop skill in the diagnosis and treatment of specific illnesses during 2 "core years" of postgraduate training, consisting of a year of straight pediatric or mixed pediatric-medical internship and a year of residency. The problem that remains in most training programs has been the inability to provide the trainee with sufficient experience in the management of consecutive episodes of acute illness in the same child. Yet most pediatricians are convinced (in the absence of experimental findings one way or the other) that continuity of care is more effective than episodic care, that it requires special experiences to learn how best to provide such care, and that training programs must somehow achieve this goal. A few experiments are now under way to provide such experience in the required second year of pediatric residency and the recommended third year of residency.

No training program has been able to provide continuity of care for all of the patients it tends, but in recent years many have developed special programs for small groups of patients under a variety of names—"comprehensive care," "family health," "continuity care."^{7, 8} Most of these programs provide physicians with 1 to 3 years' experience in caring for the same children. While this is admittedly limited continuity from the family's standpoint, it is far better than no continuity at all, the norm for most persons who use teaching hospitals as their central source of medical care. Such medical school programs as the family health care program at Harvard University, the family continuity program at the University of Rochester, and the family health program at Yale University are examples of these small-scale teaching efforts. The next step is to develop continuity of care for all children who receive their medical care from hospital clinics, a difficult but necessary task.

Most of the new teaching programs that provide continuity of care to some patients offer both preventive and curative services for the children included in the program. True, the few children that any one physician can care for during his internship or residency training make these programs a bit "precious." They do not give the physician a realistic idea of how he will have to function in practice when he is faced with the enormous demands of an expanding child population. However, they do offer the trainee his first opportunity to develop the skills entailed in providing preventive services, skills that take a great deal of time to acquire.

The training experience

A key to the success of these introductory continuity programs is the provision of an adequate number of competent, experienced, and enthusiastic teachers and the careful selection of the families to be served. Most of these programs stress the skill involved in developing good doctor-patient relations; in diagnosing and managing developmental disorders; and in taking into account the social components in health and illness, the role of the family, and the role of the health team in providing continuity and comprehensiveness of care. To achieve their purpose, they usually try to give the pediatricians in training experience with families from various social classes and educational background and having various kinds of problems.

In such programs the trainees cannot be expected to learn "on their own." To expect them to do so denies the need for this type of program entirely, for if no "teaching" were necessary, physicians could wait to develop such skills until they are in practice. The value of such training during the residency training period is that then the residents can test out different methods of providing pediatric care without the pressures of time that will occur in practice; through seminars they can probe deep into present knowledge about ways of providing comprehensive pediatric care; and, perhaps most important, they can work with the teaching staff to study and improve pediatric methods, thus contributing to what Romano has called "cumulative knowledge,"⁹ a body of knowledge that can be added to by each generation of doctors and transmitted to others.

In addition to teaching methods of care, the faculty of some of these programs engages in research into new methods of delivering services and transmits to the trainees an ability to evaluate such methods criti-

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ally and continually as a part of their function as physicians. This kind of teaching is expensive, but no more so than the teaching of biomedical research, an accepted part of most residency training programs.

Areas for experimentation

Because the health of the child is closely related to the well-being of other members of his family,¹⁰ the growing number of these special training programs are emphasizing a family focus in the care of children.^{11, 12} In these experiments, all children in a family receive first-contact medical care from members of the same health team (usually consisting of physician, nurse, social worker, and, in some instances, auxiliary health workers) and efforts are made to acquire greater knowledge than usual about the parents, their background, way of living, and problems. An experiment is under way now in Boston to determine how much difference, if any, it makes in the health of children for them to have medical care provided with a family focus.¹³ If this and other experiments prove that family-focused care is the better method, we shall have greater incentive to develop skill in family diagnosis and therapy in a combined program for internists, obstetricians, and pediatricians and even to promote the training of general family practitioners.

After many years of teaching continuity care within the walls of a teaching hospital, I have come to the conclusion that teaching hospitals, while admirably organized to care for and teach consultative care, are not the best sites for providing primary care or for the training of house staff in these comprehensive family-focused programs. They are usually too remote from the patients they serve, their staff members find it hard to shift from consultation to primary care, and they present unavoidable administrative blocks such as long waits to register, impersonal staff attitudes, a size frightening to many patients, and special difficulties in establishing family record systems.

However, the new neighborhood health centers being established in many communities with the help of the Office of Economic Opportunity, the health centers for migrant agricultural workers established with funds from the U.S. Public Health Service, under the Migrant Health Act of 1962, and the projects for the comprehensive medical care of children and youth being established in low-income areas with support from the Children's Bureau, under the 1965

amendments to the Social Security Act, provide ideal opportunities for training pediatricians in the neighborhoods where their patients live.

Well-child supervision, an activity that occupies 50 to 70 percent of most pediatricians' time, has generally been poorly taught. New approaches to this aspect of pediatric care, derived from experimentation and study, are especially needed. Prevention should not be separated from curative medicine. Moreover, in view of our serious shortages in medical manpower, it is unrealistic to teach pediatricians in training that the doctor is the only person who can provide preventive services or that such services must always be provided on a one-to-one basis with every patient receiving the same services. I believe that, to be a realistic preparation for the future, pediatric training must provide physicians with experience in caring for a large number of patients in the most efficient way. Thus a goal for the third year of post-graduate training would be to make the resident proficient in the use of techniques for screening children needing special attention and for working with parents in groups, although these processes in practice will usually be carried out by other members of the health team.

Manpower problems

A review of some figures on medical manpower will show why the physician cannot be expected to provide all the services needed. In recent years the number of physicians available to deliver continuing primary medical care to children has steadily declined in relation to the child population. While in 1940 there were 345 general practitioners per 100,000 children under 15 years of age, in 1961 there were only 135 per 100,000, a decline that has not been offset by the increase in pediatricians from 7.3 to 16.3 per 100,000.¹⁴ The average child under 5 years of age receives outpatient attention from a physician about six times a year. Roughly 60 percent of all child-physician contacts are in a physician's office; 5 percent, in the child's home; 15 percent, in a hospital clinic; and 20 percent, through parents by telephone.¹⁵

If the proportion of general practitioners in the population continues to decline at the current rate and if children are to have from pediatricians the same number of physician contacts they have now, we will need 115,000 pediatricians by 1980 in contrast to our present 15,000! Generous estimates indicate that only about 135,000 physicians of all kinds will be practicing between now and 1980.¹⁶ Clearly we

cannot expect the great majority of these physicians to devote themselves to the medical care of children.

True, some demands on pediatricians may be unnecessary. Many middle class mothers have been led by both the press and members of the health professions to expect "magic" cures for self-limiting illnesses and to have little confidence in their own child-caring abilities. However, we know there is a great deal of real, unmet medical need, especially among low-income groups. For example, infant mortality rates are higher in this country than in 10 others and the highest rates here exist among those portions of our population with the least amount of medical care. Provisions in this country for early diagnosis and adequate treatment of presymptomatic chronic conditions such as vision and hearing defects, environmentally produced developmental retardation, and emotional and orthopedic problems leave much to be desired. Also, lack of available medical care and the presence of social problems have put the early diagnosis and appropriate treatment of acute infections such as otitis media, streptococcal infections, and meningitis beyond the reach of many children.

All of these unmet needs will produce greater demands for health services as programs are developed to remove the economic barriers to medical care and reach out to the unserved portions of our population. To expect to solve the manpower problem through decreasing parent the unnecessary demands of parents is an illusion.

The health team

One suggestion that holds promise for alleviating the manpower problem is to recruit persons other than physicians to carry out, as members of a health care team, some of the services long expected of the physician.¹⁷ But this raises some as yet unanswered questions: Which of the physician's current functions should other health workers carry out? To whom can they best be delegated? What effect will this sharing of the patient have on the doctor-patient relationship?

Nurses naturally come to mind first as the most appropriate persons to carry out such services. They have a long tradition of working with physicians and seem more acceptable to patients than members of other allied professions.^{18, 19} Unfortunately, they too are in very short supply and their hospital-based training does not adequately prepare them for the tasks needed in an ambulatory setting.

Public health nurses, who are perhaps best equipped to carry out some of the physician's present functions are in even shorter supply. Nurses who have retired from employment to raise families do represent a significantly large pool of unused manpower, however, and comprehensive care programs might experiment with ways to recruit and reeducate them. Their maturity and practical experience in raising families would seem to be advantageous for the task that would be expected of them.

How much and what type of training this type of "auxiliary physician" would need is not known nor is it known whether it is better to give such an auxiliary worker a shorter initial training course than is usual in professional training followed by continued inservice training with all members of the health team or to continue to require the long initial training period customary in our professions. Experiments are needed in the training programs of all health professions to determine whether they can be made less rigid and still give training broad and deep enough to enable the trainee to adapt to changing problems and to make independent judgments, or whether they must continually lengthen the initial training programs, as has been the trend in the past two decades.

But even though we experiment with new ways for physicians and nurses to function on the health team and with altering their training accordingly there is little hope that an adequate number of members of either profession can be prepared to meet the needs in the next decade.

We need more experimentation in the training and use on health teams for mothers and children of persons indigenous to the neighborhoods being served. Such workers have been found, especially in the developing countries, to be effective in bridging the gap in communications between professional persons, most of whom are of middle class origin and the population with the greatest health needs—the low-income, uneducated portions of the population.²⁰ A similar communication barrier between professional workers and the patients they serve frequently exists here, especially in programs serving slum neighborhoods.

However, far from being only second-class medicine for the poor or being necessary only until more professional people are trained, a health team that includes neighborhood workers may result in more effective (as well as less expensive) medical care in all types of neighborhoods, even in the affluent suburbs, than does the present system.



Well-child supervision, as provided by this pediatrician in a neighborhood health center, occupies 50 to 70 percent of the modern pediatrician's time, a fact with important implications for pediatric training and the planning of health services.

For example, we know that a large proportion of children with acute streptococcal disease do not complete the necessary course of oral penicillin, whether prescribed in a clinic or in private practice. Recent studies by Charney and associates show that the personality of the mother and her relation to the physician are important factors in such negligence.²¹ Perhaps help in understanding the need for such therapy could be given the mother by a member of the health team who as a mother herself has experienced problems in carrying out a doctor's orders. At the same time this "indigenous health assistant" might bring to the physician and nurse a greater understanding of the needs of their patients and the problems they face.

With specific training for specific tasks, such nonprofessional health assistants might also develop skill in advising mothers on aspects of infant feeding, child care, and child rearing. Before launching any large-scale training program for such workers, however, we need more studies on what the needs of the patients are and the kind of training it would take to meet them.

A major problem in the development of such workers, however, is in determining the degree of

responsibility they can be given for making decisions. Obviously, nonprofessional assistants must work very closely with the other members of the health care team not only to benefit from continuing on-the-job training, but also to assure the patient of easy access to professional workers when needed.

For example, in developmental testing, nonprofessional assistants might be trained to perform simple developmental screening tests to determine if certain developmental tasks have been achieved by a given child—a yes or no decision. The more difficult decision of what the results of the test mean and what should be done about them should rest with the professional person.

It should be recognized that one nonprofessional assistant cannot learn to do everything. Protection of the quality of care requires that each such assistant be trained for and function in a limited and specialized area. However, this poses a problem, for several assistants may therefore be needed in the care of one child. Determining the number of such assistants acceptable to patients and staff is a problem calling for extensive experimentation, for at some point the size of the health team can become too large for effective communication.

University programs for training pediatricians are in a strategic position to experiment in combining such new methods of providing care with new methods of training. Not much can be done along these lines, however, unless efforts are also made to train persons for teaching and evaluating methods of care. Such training might be offered through fellowships to pediatricians who have completed 2 years of residency training. Some programs for training teachers in ambulatory care are in fact now in existence at the medical schools of Harvard University and the University of Rochester under Children's Bureau sponsorship.

Chronic care

With the addition to the health team of more auxiliary workers, physicians will have more time to spend on the care of chronically ill and handicapped children. Here the skills of pediatricians are particularly needed, along with the skills of those pediatricians who have developed subspecialties in specific diseases or handicapping conditions. Under present requirements of the American Board of Pediatrics, subspecialization in specific areas such as cardiology or allergy added to the broad base of pediatric training can be accomplished in an additional 2 years after

the 2 core years of pediatric internship and residency. But even the pediatrician who is not planning a subspecialization might well select two, three, or four chronic diseases on which to concentrate during his third year of postgraduate training. In this year he should also learn to work as a member of a health care team, one different from the team for primary care but functioning under the same principles for working together.²²

It is becoming increasingly difficult for the pediatrician in private practice to provide adequate services in his office for the chronically ill child, for he is not likely to have there the technical equipment or the easy access to consultation of specialists and allied health workers such as medical social workers and physiotherapists that a hospital-based program affords. Thus the training programs have an important role to play in helping pediatricians know how to work on such teams as part-time subspecialists while they are in general pediatric practice.

For example, in the cystic fibrosis clinic of the University of Rochester School of Medicine and Dentistry, which has a full-time staff consisting of a pediatrician, director, and consultants in infectious disease, allergy, metabolism, and other specialties, the continuing care of the children is the responsibility of a few pediatricians who are in private practice but who are specially trained in cystic fibrosis and come to the clinic regularly. Both they and their patients seem to benefit.

In conclusion

In this review I have concentrated on training physicians to understand the kinds of medical services needed by children and to work as part of a health team to meet these needs, rather than on the training of the physician per se. I believe this emphasis is essential if pediatricians are to be prepared realistically to meet the health needs of the children of this Nation.

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Human development is a drama with many actors; sometimes one, sometimes another player has the center of the stage, but in this drama no one player is ever on stage alone.

Dorothy V. Whipple, M.D., "Dynamics of Development: Euthenic Pediatrics," McGraw-Hill Book Co., New York, 1966.

INCONSPICUOUS FAMILIAL DISABILITY

DAVID ANDERSON

ERIC KNOX

Nodding our apologies to the caretakers of good writing and good manners, we have decided that we must begin our essay by talking about ourselves. We are second-year medical students at the University of Minnesota. The curriculum here is set up to leave the summer between the freshman and sophomore years free. During this free period, the two of us, fortified by backgrounds in gross anatomy, histology, biochemistry, and a smattering of other sciences, signed up for fellowships within the pediatrics department—and, more specifically, for work with a group involved in establishing an educational model of comprehensive health care for the children of families regarded as poverty stricken. [Comprehensive Health Services for Children and Youth in Minneapolis, Children's Bureau Project No. 603.]

To call us neophytes in the craft and society of medicine would be charitable. And this is a point we want to establish at the outset: our observations in our encounters with the people that are to be patients in the proposed model clinic were unrestricted by the preformed expectations and conclusions that education and prior experience might sometimes produce—and equally lacking in the acuity that education and experience bestow. We point this out to establish our openmindedness, and we hope that our readers do not at once dismiss our viewpoint as only ignorant and naive.

We spent the first part of the summer helping to launch the initial phase of the project. This involved health screening for preschool-age children in the area the comprehensive care unit is to serve. From the first group of medical histories taken in

the project (about 50 in all), each of us chose, with the aid of our advisers, one family to study intensively and follow as its members used the clinic. Our feelings about one of these families prompted us to set down our ideas about the need for a new approach in dealing with the problems of a type of family we think will be more and more prevalent.

The Smith family is noteworthy perhaps only by its inconspicuousness. Its very lack of notability seems to be its greatest liability. This family represents to us a self-perpetuating subterranean mode of existence, removed from and unheeded by the active currents of society. This mode of existence fits no labels because it has not aroused the interest of the labelmakers—the sociologists, psychologists, and public health people. Its “pathology” is just beginning to be understood. Those engulfed in it are the school dropouts, the chronically or intermittently unemployed or unhappily employed, the people of whom nothing is expected. What is so striking to us is that their feelings of suspicion and habits of withdrawal from society, themselves symptoms of pathology, seem to be passed on from generation to generation almost like a dominant gene, the pattern broken only when the pathology is starkly manifested in ways that society recognizes and abhors—alcoholism, crime, and the other diseases for which society has its agencies. Our great agencies, praiseworthy as they are, we feel, are treating only the secondary manifestations of a pathology whose origin and reinforcement are in the family dynamics of the people involved.

Pattern of self-defeat

Perhaps the best way of defining what we are talking about is to describe what we saw in the Smiths. Because of the inexpert nature of our observations we can hope only to make clear the dominant patterns of interaction. The parents and six children, ranging in age from Bill, 18, to Daniel, 2, occupy a house in a shabby section of the city. Mr. Smith does his best as a provider though he is untrained and must resign himself to the uncertainty of changing needs for unskilled labor. What he earns each year is enough to keep his family from serious need, with some aid from the city relief program.

The caseworker who oversees the administration of city funds for this family finds little to arouse the enlistment of her talents since the Smiths are thrifty, upstanding, and seemingly do the best they can.

Their condition cannot be characterized by the more colorful, classical picture of poverty with its images of moiling slums, irresponsibility, crime, and aggression. They are of the displaced, the passive and withdrawn, a segment of society present always, but now, with the increasing complexity and speed of our world, bound to include more and more people.

Our primary concern is the emerging pattern of self-defeat we see in the children of Mr. and Mrs. Smith. We realize that the particular constellation of personal traits and interactions in the Smith family is characteristic of this family only. But we want to show that the family dynamics must be understood if we hope to head off the development of six similar next generation Smith families.

The key to the problems in this family appears to be Mrs. Smith. Her role in the interpersonal relations of the family is more active than her husband's. In contrast to the easy-going Mr. Smith, she is wound tight by anxiety and suspicion. Within her home she appears to function competently; keeping the home neat and clean is obviously very important to her. But her ability to function evaporates when she leaves the security of her home. On one day that we visited the Smiths, she had just returned from an unplanned excursion with her father to the Minnesota State Fair. She had become exhausted almost at once, complained of a severe headache, and asked to be taken home. She said she probably would not have gone at all if she had had time to think about it.

It seems to us that Mrs. Smith is able to maintain at home a rather precarious equilibrium that is seriously threatened if she ventures away. She expresses a variety of prejudices, fears, and dislikes, all of which excuse her from having dealings with her neighbors. She retains strong dependency bonds with her own father and brothers and sisters.

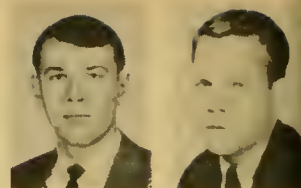
The children

The same patterns of dependency we note in Mrs. Smith are developing in her children. Supporting this is the same type of suspicion and withdrawal.

Bill Smith is a good-looking, husky fellow who, from outward appearance, should have the world on a string—that is, if he were not a high school dropout. As his mother spoke about Bill, we began to understand the familial nature of the withdrawal pattern.

Though tests show Bill to be normally bright, he has never developed much interest in school. In

David Anderson, left, and Eric Knox are second-year medical students at the University of Minnesota. Their observations are based on experience at a neighborhood pediatric clinic in the Minneapolis comprehensive health care program for children and youth supported by the Children's Bureau.



fact, he does not seem to be interested in anything at least for any length of time. At present he leads a sedentary existence, lounging about the house and demonstrating reluctance to venture away.

Here's a young man who has withdrawn himself from the world. He has quit every job he has had as his interest began to pall—except for a brief stint as a supermarket carryout boy, a job from which he was fired for being “unfriendly.” He has expressed mixed feelings about joining the armed service, feelings that mirror his mother's own ambivalence. She feels that a “hitch” in the Army might provide Bill with the discipline and responsibility he needs but, on the other hand, that it might be too much for him. The issue was resolved when Bill failed the Army psychological test.

Next oldest is 16-year-old Sandy, a high school junior. She manifests her fear and implements her withdrawal through somatization. She has an atopic allergy, probably for wool, though the allergy has not been exclusively incriminated since her symptoms appear in conjunction with altered emotional status. The school nurse feels certain that the psychosomatic element is of the greater etiologic importance, and Mrs. Smith says that Sandy often uses an outbreak of rash as an excuse to stay home. Sandy's world, like Bill's, is becoming smaller and more insulated as she approaches the time when the healthy tendency for a young person is to move toward independence. Like her mother, Sandy is satisfied with no less than an impeccable house, but on the side of housework “she doesn't really like to do much of anything,” Mrs. Smith tells us.

The most severely affected child is Tommy, age 11. Tommy's case is the one that brought this family to our attention and made the Smiths “interesting,” for only in Tommy has the familial pathology emerged in a way that arouses our interest as healers—he has acute behavioral problems. Having admitted our lack of training, we will not presume to explain the

reasons for the greater severity of Tommy's affliction. Two interesting leads for more experienced observers might be found in Mrs. Smith's assertion that Tommy's birth was certainly the most difficult—"his head was twisted the wrong way"—and in his once close relationship with a maternal uncle who committed suicide several years ago.

In Tommy we see aggression and destructiveness, yet beneath are the same kind of fear and withdrawal as in other members of the family. Except for school he refuses to leave the home, unless it is with his beloved grandfather, Mrs. Smith's father. Tommy feels extremely threatened by persons outside his family—including the neighbors of whom Mrs. Smith is so suspicious. Tommy, like Sandy, often develops physical symptoms. He suffers from headaches, stomachaches, and backaches with no apparent organic causes. He has been receiving special aid in school for a reading difficulty. Tommy's problems are recognized and he will undoubtedly be the subject of much professional attention. We wonder if he might not be the most fortunate of the children.

The three younger children, Kathleen, 7, Penny, 5, and Daniel, 2, do not as yet show the effects of the pattern we have been describing. It is, of course, impossible to know whether their emotional state will deteriorate as they grow older and the influences of the family have had longer to work.

Why take them on?

If the Smiths were minus Tommy, we wonder if they would arouse our nascent professional interest. We also wonder about how much attention this family would receive by those who share our values as products of the middle class from which professional healers, nurses, social workers, and doctors almost always come. For, at first glance, the Smiths could seem to be a benign unit of society and any special interest in them superfluous. Why spend time on them when they seem to be compensated for their weaknesses and are not hurting anyone?

We asked ourselves this question when after a closer look we were trying to formulate pragmatic reasons to back up our feelings that the time should be spent. Perhaps such feelings are themselves the most important reason. The members of the Smith family suffer from a disease that makes them unable to function productively in the world as it is today. Therefore, as a healer one has the responsibility for treating them as best he knows how. With some

thought and projection the pragmatic reasons become clear as well.

One can be sure that, without intervention in the natural course of such family pathology, society eventually will be adversely affected by the more malignant forms that such pathology may take. When the suspicion and withdrawal are overlaid with aggression, as in Tommy's case, crime is a possible outlet if the pattern is not interrupted. Or when such traits are overlaid with self-destructiveness, as in the uncle's case, suicide might result. Less spectacular perhaps is the burden that Bill's expectations as one of the chronically unemployed represents as a future drain on welfare funds.

Then there is the fact that treatment of the symptoms—from the somatic manifestations of fears to the financial necessity for welfare—without trying to treat the primary pathology is bad medicine, and, we assume, bad social work as well.

Lacks in treatment

Ideally from here we should proceed to the solutions of the problem we have been discussing and point out how we can update or sharpen our methods, but we simply do not have the answers. All we can do is describe how the Smiths have been dealt with in the past and what we feel has been lacking in this treatment. We will in the end make a very general suggestion about a possible starting point in finding the ways to remedy this lack.

Briefly, the treatment that the Smiths have received up till now has been too late, too fragmented, and too inaccessible. Both the nature of the family and the nature of traditional health resources have contributed to these faults.

It seems to us that prevention of the pattern of self-defeat we see developing in the Smith children is possible, but only through early diagnosis and direct intervention. As we have mentioned, except for Tommy the family does not seem remarkable in the cursory look that most busy health practitioners have time to give. However, of equal importance in the delay of diagnosis and treatment is the Smiths' reluctance to seek outside "interference." Like many people in their condition, they must be convinced that a family member is acutely ill before they seek help.

For the Smiths the primary medical resource is the county general hospital and the charity facilities of one of the community hospitals. Both are excellent establishments. Sandy's emergency record at

the general hospital reveals part of the problem.

In eight different entries, spanning 4 years between 1962 and 1966, the admitting complaint is her acute skin symptom. Even the first examination yielded the diagnosis of neurodermatosis, and symptoms of anxiety were noted then and during several subsequent examinations, but it was over a year from the initial complaint before Sandy was scheduled for the allergy clinic. Although the emotional elements of her disease were suspected from the beginning, the expenditure of effort has been primarily to find a salve for maintaining her complexion—precious time has been lost.

From Sandy's records, and Tommy's as well, the fragmented nature of the treatment they have received is also well illustrated. Again the attitudes of the Smith family toward health agencies—to be used only in acute situations—as well as the nature of the facilities themselves are implicated. The fragmentation we refer to exists within the sphere of medical treatment and, on a larger scale, among the various agencies responsible for health in its broader connotation. For families unable to afford a private doctor, the emergency room provides the only recourse in time of need. For diagnosis and treatment of acute illness or injury, we think, the emergency room is ideal. However, for the chronically ill, for whose treatment knowledge of the development and course of the disease is extremely important, the necessary continuity of treatment is threatened by the turnover of personnel and shortage of time that are the conditions of the emergency room.

The availability of outpatient specialty clinics does not entirely solve the problem. Sandy's attendance at the allergy clinic was only occasional, depending on the severity of her skin condition at the time. Tommy's appointments at the pediatrics clinic were usually kept only when he had one of his headaches. A striking and saddening fact is that in almost every entry in the records of these two young people the examining physician expressed the opinion that emotional factors were involved in their symptoms. That the traditional facilities are partly responsible for the difficulty in dealing with these factors seems to us an unhappy and unnecessary situation.

The cross aims and overlapping aims of the various agencies of the community that in the composite are responsible for health in the larger sense of the word—overall well-being—represent another level of fragmentation. The Smiths have not been the subject of much attention from the various community agencies. But through our concern with them, we

have seen how the total pattern of family difficulties may never be discerned by the observations made from single, nonintegrated, though insightful points of view. The city welfare worker undoubtedly knows a great deal about the Smiths' financial expectations. The school has recognized Tommy's reading and behavior problems. A high school nurse perceives the elements of school phobia in Sandy's allergy problem. But who is going to put these observations together, relate them with what goes on in the home, and see the family as a whole?

Intermediary needed

What it all boils down to is that the care the Smiths have received has been inadequate because of its inaccessibility—inaccessibility not in the physical sense or even in the economic sense, but in the sense that a gap exists between the family's needs and the resources of the community. The gap is opened by the aforementioned reasons behind the tardy and fragmented nature of the care the community offer. We feel that it might be spanned and care made accessible to the Smiths by a person or group whose primary function is to gain as complete an understanding as possible of the family and its dynamics, whose primary concern is to prevent disease in all connotations of the word, and whose tools are the specialized agencies already operating in the community.

What we have in mind is an intermediary between the family and community resources, one with sufficient understanding to fit the care to the need. To attempt to go beyond this very general suggestion would rapidly exhaust both our space and our ideas—indeed the questions that arise concerning the ideal training for carrying out such a role, the proper relationship of such an intermediary to the family and to the agencies involved, and financial arrangements possible are those for which answers will be found only through experience.

The Smiths, while unique, have represented to us an example of a growing number of displaced people—removed from the mainstream of today's demanding way of life. We feel that the key to understanding the origin and propagation of their pattern of self-defeat and to averting a predictable course of events is in the workings of the family. Beyond clearing slums, training high school dropouts for employment, and instilling hope in the hopeless, we in this country must find ways of breaking the chain of human interactions that perpetuate many of our social problems.

a psychiatrist
considers
the origins of

VIOLENCE IN GHETTO CHILDREN

ROBERT COLES, M.D.



When I worked as a child psychiatrist in a children's hospital, I spent most of my time with middle class children whose parents very often seemed earnest and sensitive; certainly they were worried about their children, at times excessively so. The boys and girls, for their part, were usually quiet and controlled. They were suffering from "school phobias" or the various fears and anxieties that have been described by a generation of psychiatrists. If they were disobedient and loud, usually it was a specific form of disobedience I saw, a very particular noisiness I heard, all connected to something they dreaded or dared not to look at. In a sense, then, the unruliness I noticed only confirmed my impression of a general restraint (emotional tidiness, I suppose it could be called) that middle class children by the time they are 2 or 3 years old are likely to have acquired, never to lose.

Yes, there are the usual signs of aggressive tendencies in the "latency years" (the years preceding puberty when sexual urges are quiescent)—the bold and even nasty games, the play that seems involuntarily brutish—until a long look reveals how curiously formal, even restrained, the unruliness of these children actually is. Despite all the "drives" one hears psychologists and psychiatrists talk about—the urges of desire, spite, and hate that continuously

press upon the child's mind and in dreams or day-time fantasies gain control of it—the fact remains that by the time middle class American children first reach school, at age 5 or 6, they are remarkably in control of themselves. As a result, when the violence in such children erupts in a psychiatrist's office during a session of drawing or in the midst of a game played by the psychiatrist and the child, it is almost a caricature of violence—violence so safe, so exaggerated, so camouflaged, and so quarantined that the very word seems inappropriate.

We in psychiatry are often accused of seeing only the drab and morbid side of human nature. If it would be any comfort to people, I suppose we could easily make partial amends for that morbid bias by letting it be known how overwhelmingly law-abiding man is: if he is vindictive, he is likely to be so toward himself. Psychiatrists spend most of their time helping people take a look at violence removed enough from their own recognition to be, in effect, somebody else's property. If in time the patient, whether child or adult, owns up to what he secretly or temporarily senses, he will be in greater, not less, control of himself. Thus, I remember treating a 10-year-old boy who drew wild and vicious scenes, filled with fire and death or at least an injury or two. When I wanted to know about what was going on, he

let me know the score rather quickly by pointing to the people in his pictures and saying, "I don't know, you'd have to ask them."

A different "ball game"

Not everyone in America is brought up to disown violence so consistently that its very presence in his own drawings can be adroitly (that is, innocently) denied. In the past few years, as I have worked with children in both southern rural slums and northern "ghettos," I have come to appreciate how useless it is to think of, or judge, the growth and development of the children of the depressed poor in the same way I ordinarily view the development of middle class children. It is, as one boy in a Boston ghetto recently reminded me, "a different ball game when you're out in left field, instead of in there pitching."

If we consider what a child of the slums goes through, from birth on, and if we keep a special eye on what in his experience may make him "violent" even at the age of 7 or 8, we may well gain, rather than lose, respect for the upbringing he receives. In fact, I have seen how much childbearing means to poor women: it is the one thing *they* can do, and do creatively. It is the one chance they have to show both themselves and others that there is hope in this world, as well as the next.

By pointing this out, I am not arguing against keeping families to a sensible size, nor overlooking the impulsive, dreary background that is also commonly associated with pregnancies among the poor, whether in or out of wedlock. I am simply saying to others what a mother once felt she had to let me know:

They all tell us to cut down on the kids, cut down on the kids, because you can't keep up with them as it is, and even a few is too much if you're on welfare for life, the way we has to be, like it or not. I tries to cut down, and I want to, but it's not so easy. You have to watch your step all the time, and we can't afford the pills they have for others.

Anyway, it's the one time in my life I really feel like I'm *somebody*, like I'm doing something. People come around and expect me to feel ashamed of myself, like I've done something wrong, and I'm adding to crime on the streets—that's all you hear these days, *our* crime, not anyone else's—but instead, I feel proud of myself, like I can at least make a baby, and maybe he'll have it better than us, who knows, though I doubt it.

If we want to help this woman keep her family small, I hope we also want to give her what she needs to feel like the *somebody* she still desires to be.

I know this woman's children, and already I have

seen them readying themselves for what their mother herself calls "the goddam street." Each one of those children has been held and breast fed in ways I think some middle class mothers might have cause to envy. The flat is cold and rat infested, but there is real and continuing warmth between that mother and her babies. "Symbiotic" some of my colleagues—who have a name for everything—might call the relationship of that mother and her children; it is also a bond that unites the fearful and hungry against the inevitable day when the home has to yield to the outside.

Preparation for the street

Slum children do not go unprepared when the time comes, contrary to the assumptions of some social critics who can only see the life of the poor as aimless, neglected, and always "deprived." Chance are these children receive specific and brutal instruction about the "realities" of life at the age of 2, 3, or 4 so that when they emerge from the home to the police, the hoods, the addicts, the drunks are already familiar, and what happens in the schools or on playgrounds is not disappointing but expected. The mother I have already quoted has also testified to the morality and lawfulness she tries to inspire in her children:

I don't know how to do it. I don't know how to keep n kids from getting stained and ruined by everything outside. I keep them close to me, and sometimes I feel like everything will be O.K., because they know how much I want for it to be and they'll go make it be, the way I thought I could. But after a while they want to go out. You know how a kid is when he's 3 or 4, he wants to *move*, no matter where, so long as I keeps going. And where can he move in here? So I let them go, and I stop and say a prayer every morning, and ask for them to be saved, but I have to say it, I'm not expecting my prayers to be answered, not around here, I know.

And when the kids come back upstairs, I give them a look. If I have the time, to see what's on their face, and what they've learned that'll make a mess of everything I try to teach. And I can tell—I can tell from day to day what's getting into them. You know what it is? It's the Devil and he tells them to give up, because there's no other choice, not around here then isn't.

She is a churchgoing woman, as are many of her neighbors. I have found that she knows her Bible better than I or my neighbors, and in fact she doubtless puts more store in prophetic, messianic Christianity than most Americans do. When her children start walking and talking, she starts teaching them rules and fears—enough of both to satisfy anyone who is worried about the decline of "morality" in America.

At least in that home, and others like it I have visited, children are not allowed free reign. Instead they're told to obey, and they are swiftly slapped or punished if they falter.

Over the years I have learned how loyal slum families can be to America's ethic of "rugged individualism." Children are taught through the ubiquitous television to seek after all the products of our proud technology: the cars that can speed faster than any law allows; the records and clothes whose worth can only be seasonal; the bright and shiny places to frequent; the showy, gadget-filled places that not only shelter people but also make statements about their power, influence, and bank accounts. At 5 and 6 years old, ghetto children in today's America share through television a world quite similar to the one known by their wealthy age-mates. I find it almost unnerving when I see drawings from a child not yet old enough to attend school that show the appetites and yearnings our advertisers are able to arouse. Precisely what do such children do with such wishes and fantasies, besides spell them out on paper for someone like me?

In school

When a child of 6 or 7 from the ghetto meets up with the politics of the street or the schoolyard, he brings along both the sensual and the fearfully moral experience he has had at home. Slum children live at close quarters to their parents and their brothers or sisters. They are often allowed to be very much on their own, very free and active, yet they are also punished with a vengeance when distracted or forlorn. Parents suddenly find an issue forced, a confrontation inevitable. They face an ironic mixture of indulgence and fierce curtailment.

Such children come to school prepared to be active, rigorous, perhaps much more outgoing on an average than middle class children. But they are quick to lose patience, sulk, feel wrong and wronged and heated by a world they have already learned to be impossible, uncertain, and contradictory. Here are the words of an elementary-school teacher who has worked in a northern ghetto for 3 years and still feels able to talk about the experience with hope as well as bitter irony:

They're hard to take these kids, because they're not what you think when you first come, but they're not what you'd like for them to be either. (I don't mean what I *used* to like for them to be, but what I want for them now.) They're fast and clever, and full of life. That was the hardest thing for me to

realize—that a boy or girl in the ghetto isn't a hopeless case, or someone who is already a delinquent when he comes into the first grade. The misconceptions we have in the suburbs are fantastic, really, as I think back—and remember what I used to think myself.

I expected to find children who had given up, and were on the way to fail, or to take dope, or something like that. Instead it was in a lot of ways a breath of fresh air, talking with them and teaching them. They were friendlier, and they got along better with one another. I didn't have to spend half the year trying to encourage the children to be less competitive with one another. We don't call middle class children "culturally deprived," but sometimes I wonder. They're so nervous and worried about everything they say—what it will mean, or what it will cost them, or how it will be interpreted. That's what they've learned at home, and that's why a lot of them are tense kids, and, even worse, stale kids, with frowns on their faces at ages 6 or 7.

Not a lot of the kids I teach now. They're lively and active, so active I don't know how to keep up with them. They're not active learners, at least learners of the knowledge I'm trying to sell them, but they're active and they learn a lot about the world, about one another. In fact, one of the big adjustments I've had to make is realizing that these kids learn a lot from one another. They are smart about things my kids will never understand. They just don't think school is worth a damn. To them it's part of a big outside world that has a grip on them, and won't let them get any place, no matter how hard they try. So what's the use, they ask themselves; and the answer is that there isn't any use—so they go right on marking time in class until they can get out.

We teachers then figure they're stupid, or they're hopelessly tough and "delinquent," or their homes are so bad they'll always be "antisocial" or "incorrigible." I've found that when they're playing and don't know I'm looking they are different kids—spontaneous, shrewd, very smart, and perceptive. Then we go back into the classroom, and it's as though a dense fog has settled in on all of us. They give me a dazed look, or a stubborn, uncooperative one, and they just don't do anything, unless forced to—by being pushed and shoved and made to fear the authority they know I have.

We have compared notes many times, this teacher and I. One child we both know is a boy of 8 who does very poor work in school. He is a belligerent child, a troublemaker. I see him in his home because his brother is going to a predominantly white subur-

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ban school, one of the very few children in the neighborhood who does. Their mother, living on public assistance with six children and no husband, has her hands full. She finds her "difficult child" smarter than her "model" one, the boy I watch riding a bus that takes him away from the ghetto.

The teacher and I agree, the "difficult boy" is a smart boy, but an impatient, agile, and provocative boy. He is headed for trouble, but as I talk with him I find *myself* in trouble. I have asked him to draw pictures—of himself, of his school, of his home, of anything he wishes. I get from him devastating portrayals: schools that look like jails; teachers whose faces show scorn or drowsiness; streets and homes that are as awful to see on paper as they are in real life; "outsiders" whose power and mercenary hostility are all too obvious; and, everywhere, the police, looking for trouble, creating trouble, checking up, hauling people to court, calling them names, getting ready to hurt them, assault them, jail them, and beat them up—even if they are children.

Once I asked the boy whether he *really* thought the police would hurt someone of his age. He said: "To the cops, everyone around here is a little bad boy, no matter how old he is or how many grandchildren he has around."

At moments like that my psychiatric, categorical mind finds itself stunned and for a change ready to grant that boy and others like him freedom from the various diagnostic, explanatory, or predictive schemes people like me learn so well and find to be (in our world) so useful.

An impossible situation

I often find welfare workers as well as the police present in the pictures ghetto children draw. They stand near the police like dogs, caricatures of themselves, with huge piercing eyes, ears that seem as twisted as they are oversize, and mouths either noticeably absent or present as thin lines enclosing prominent and decidedly pointed and ragged teeth. To ghetto children, as to their parents, the welfare worker is the policeman's handmaiden, and together they come, as one child put it, "to keep us in line, or send us away."

I have listened to public welfare workers and their "clients" talk, and I recognize the impossible situation they both face, the worker often as insulted as the family he visits by the rules and regulations they must contend with—and find a way around.

I often compare the relationship between the worker and their clients with one that develops in psychotherapy as for a while powerful forces pull both doctor and patient backward in time toward those early years when parents check up on children, trying to keep them on the right side of a "line" that constantly puzzles the child and perhaps also the parent more than she or he realizes.

One welfare worker recently summarized the situation for me:

They behave like evasive kids, always trying to avoid getting caught, for this or that. And me, I'm like a child myself, only an older one—always trying to take care of my poor brother and sisters, but also trying to get them in trouble or find them in trouble, so I can squeal on them.

No wonder I encounter anger, frustration, and violence in ghetto children. Everywhere things go wrong: the lights don't work; the stairs are treacherous; rats constantly appear, and they are not timid uniformed men patrol the streets, certain that trouble will appear; teachers work in schools they are ashamed to call their own, at work they judge hopeless, under a bureaucratic system that stifles them that is, if they are still alive; jobs are few, and "welfare" is the essence of the economy.

Yet—and I am writing this article chiefly to say so—the ghetto does not kill its young children. That perhaps comes later, at age 12 or 14, when idleness becomes a way of life, when jobs are nowhere to be had. For a while, during the first decade of their existence, ghetto children huddle together, learn about the world they have inherited, and go on to explore it, master its facts, accept its fate, and burn from day to day their inner energy and life, able for a while to ignore the alien outside world.

I find in these children a vitality, an exuberance that reminds me often of the fatally ill I once treated on hospital wards: for a long time they appear flushed with life, even beautiful, only to die. I remember hearing from a distinguished physician who supervised a few of us who were interns "They're fighting the battle of tuberculosis, and they're going to lose, but not without a brilliant flash of energy. It's a shame we can't intervene right at the critical moment, and help them win."

He, of course, had the faith that some day medicine would intervene—with one or another saving treatment. Ghetto people have no such confidence and I am afraid that I, at least today, share their outlook.

UNMARRIED MOTHERS —

the service gap revisited

ELIZABETH HERZOG

Very few flat and unchallengeable statements can be made about unmarried mothers and their children. One, however, seems immune to argument: during the past 25 years, the number of births out of wedlock has risen dramatically—from about 89,000 in 1940 to an estimated 291,000 in 1965. The “ratio” (the proportion of all live births that are births out of wedlock) has also risen. But what we hear about less often is that the overall “rate” (the number of births out of wedlock per 1,000 unmarried women of childbearing age) has remained relatively constant since 1957.

Those who are responsible for planning programs and giving services must be aware of *numbers*. Those who attempt to understand and interpret the nature and meaning of trends must be concerned with *rates*. And a study of rates tells us that, although many factors enter in, the chief reason for the recent increase in numbers of out-of-wedlock births is that there are more women of childbearing age today than in the past.

The reasoning behind these comments on numbers, ratios, and rates has been discussed elsewhere.¹⁻⁴ They are made here merely as background to the proposition that people concerned with helping unmarried mothers and their children can afford to relax their present anxious preoccupation with each new set of figures on out-of-wedlock births. We know that numbers have already outstripped services. The demographers tell us that numbers will probably continue to rise during the years just ahead, even if rates stand still or dip; and that this is chiefly

because there will be more women of childbearing age.

Increasing numbers threaten to increase the gap between services and needs because practitioners of all kinds are unlikely to multiply as much as out-of-wedlock births. Moreover, our ideas about service expand far faster than does our manpower for carrying them out. For the next 10 years, then, no new statistics are needed to show that our utmost efforts may reduce, but cannot close, the service gap.

Some pertinent questions

Instead of questions about trends, three other questions seem more pertinent today:

1. What factors are associated with extramarital motherhood?
2. What services are needed by and helpful to unmarried mothers and their children?
3. What can be done to reduce the rate of out-of-wedlock births?

Space permits only a passing bow to two of these questions and a brief comment on the third.

With regard to the first, the salient point is that most of the imputed causes tend to dwindle when other relevant variables are carefully controlled. The factors that so far do not appear to stand up under analysis as *the* major cause include low intelligence, broken homes, geographical mobility, and psychological or interpersonal disturbances. Any

of these factors may be involved in specific instances, but none can be held mainly accountable for *the* problem.

A factor that so far does seem to stand up against challenge, not as *the* cause of unmarried motherhood but as a major factor associated with it, is economic status. When statistics are analyzed, economic status appears to account for a good deal of the higher incidence of out-of-wedlock births among nonwhite mothers than among white mothers in this country. Although a substantial proportion of out-of-wedlock births is not connected with poverty and social disadvantage, these factors do figure in the majority of cases.

The second pertinent question about the kinds of services needed breaks down into a number of subquestions. Two of these are: (a) Do the needed services reach those they are supposed to reach? (b) Do they help those they do reach?

With regard to the first subquestion, the answer for the United States at large is a resounding "No." A rough but educated estimate is that less than one-third of our unmarried mothers receive services from social agencies near the time of the child's birth, and fewer still receive them at other times.^{2, 5}

Maternity homes in the country at large, according to recent figures, are equipped to serve less than 10 percent of the unmarried mothers.⁶ True, some maternity homes are making valiant and imaginative efforts to expand their services—for example, by serving some girls as outpatients and some in their own homes and by allowing some to live in the maternity home and go out daily to jobs in the community. However, services are far from sufficient and those we do have are not distributed evenly or efficiently. A disproportionate amount of social services has gone to those unmarried mothers who are above the poverty line, who are white, and who are likely to place their children in adoption.^{7, 8} In regard to health services the picture is somewhat different but also distressing.⁹

Strenuous efforts are being made to improve both the insufficiency and the imbalance of services to unmarried mothers, but we have a long, long way to go.

The second subquestion—how much are they helped?—is as painful as the first and much harder to answer. We do know that among the unmarried mothers reported as being served at all, a good many receive somewhat skimpy attention. Rather than dwell on the dark side, however, I would like to focus on one aspect of the effort to expand and improve services simultaneously. This is what appears to be

an increasing determination to conquer the fragmentation from which services to unmarried mothers have suffered and to achieve service programs that are really comprehensive.

The reports of research and demonstration projects reviewed at the Children's Bureau, interim reports of projects still under way, and the applications received for support of new projects, as well as discussions by people who work with unmarried mothers, reflect a conviction that fragmentation of services should be combatted and that more comprehensive services should be developed. The effort is to coordinate, combine, integrate; to develop programs that bring together health, social, legal, economic, and, where appropriate, educational and vocational services into one integrated program. Many people believe that such integration will both expand and improve services and, by reducing duplication, will do so at less cost than would be required by separate services.

The patterns and the sponsorship of attempts at such integration vary, but the impulse toward it is strong and prevalent.

A few years ago, with the help of Rose Bernstein, the Children's Bureau undertook a systematic review of reports published before 1963 of research and demonstration projects concerned with unmarried mothers, including many community programs for extending and coordinating services. The following impressions, growing out of these and later projects, draw heavily on Mrs. Bernstein's analysis.

Comprehensive services

The efforts to develop comprehensive programs have been directed primarily toward three groups of unmarried mothers: (1) those who become known to hospitals and social agencies "too late" or not at all; (2) those who do not come into the purview of community medical and social agencies, making their medical plans privately and making independent arrangements for adoptive placements; (3) those who have need of special help to continue in school or to develop vocational skills.

One major value mentioned in nearly every report of efforts to coordinate services is the gain in interprofessional information and understanding. The various professions and disciplines learn about the functions, methods, and goals of others. They are amazed at what they did not know about others and what others did not know about them. Among the professional groups specifically mentioned in the re-

port of one of the largest, most enduring, and most carefully documented projects were social workers, doctors, hospital nurses, public health nurses, lawyers, clergymen, school officials and teachers, and policewomen.

Other reports also note that social agency staff members and hospital nurses become acquainted with the varied and effective assistance offered by the public health nurses, that doctors learn more about social workers and what they do. An obstetrician exclaims with pleasure that it is a boon to know, before a girl is actually sitting in his office, what the community's social agency resources are, what the State has to offer outside of the community, and what legal regulations he must be aware of in advising her about where to go. A social worker says, "I didn't realize how much the schoolteachers can help us!"

A corollary to increased information is likely to be closer and more effective working relations.

Closely related to increased information and more effective working relations in the reports reviewed are improvements in practices and policies for seeing that unmarried mothers get the services they need: the use of referral services; an increase in referrals from agencies and individual professional people (doctors, lawyers, clergymen, school personnel, and others); and greater followthrough in an effort to make sure that the referral results in an active contact.

Except in relation to a few continuing projects, it is not clear how long these effects last since followup reports on the projects are rare. Apparently, extended duration depends on continued efforts, and in many cases lack of staff, funds, and community support have resulted in a drifting back to the predemonstration status.

That understanding and cooperation between professions and disciplines are necessary to coordinate services goes without saying. The remarkable finding was that in so many communities it took a special

project with outside funding to achieve this desirable result. It reminds me of my freshman Latin teacher in high school who had to teach us English grammar before he could teach us any Latin, because we had not learned about grammar in the elementary grades. By the end of the year, we did not know much Latin but we did know a little grammar.

The projects reviewed were completed several years ago, and it may be that by now the professions know more "grammar." Certainly efforts in this direction have been made, including some by the Children's Bureau in cooperation with the medical and legal professions.^{10, 11} Last spring the American College of Obstetrics and Gynecology devoted a session at its annual meeting to an interprofessional discussion of unmarried mothers and their problems. Various other efforts to approach these problems interprofessionally are under way. One can only hope they will continue and will increase.

Some problems

Certain problems are repeatedly mentioned in the reports. One derives from success: greater efforts to bring unmarried mothers into service frequently succeed, and immediately the available facilities become overloaded. Few program planners seem to recognize the need to be prepared for more applicants if one launches a campaign to get them, and even fewer arrange to meet the response by enlarging the staff.

One result of suddenly increased caseloads can be the shutting down of intake. In one urban demonstration project, the pressure made it necessary to give service in a much larger number of cases than had been expected and therefore to limit it in many cases to brief contacts. These brief contacts tended to be in the poorest part of the city, where most of the women were Negroes. Pressure of caseload steered a large proportion of these unmarried mothers to an agency that already knew them, the public welfare agency—where they tended to get only the services they had received before, namely, financial assistance as indicated.

This particular report was completed before the 1962 amendments to the Social Security Act, which stress service in public welfare programs, could have an effect. Some of the imbalance in services is now being corrected through the effects of these amendments and subsequent developments. But the problem of too few services for too many people will be with us for a long time.

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The most pervasive and massive problem is demonstrated more often than stated in the reports: the administrative and personal difficulties of carrying out a determination to coordinate or integrate services. The need for centralized leadership is evident again and again, as is the fact that this kind of leadership is not always welcomed or accepted. Some projects apparently succeed in working out ways of integrating health and welfare and other services. Often, however, the problems are not fully solved and not fully faced. One hears by the grapevine of foot dragging by one department in a program set up under another's auspices.

For example, a project set up under a local department of health for helping pregnant unmarried teenage girls continue their schoolwork found that the education department assigned to the project its least qualified teachers. Only after prolonged effort was a better teaching staff mustered. Another project, set up under a local education department, traveled an unnecessarily thorny path to building in the desired social services. Occasionally, also, one hears of jurisdictional difficulties between two social agencies or two sources of health services, even though the final report presents a rosy, harmonious picture.

Even without interagency friction, a client sometimes falls between two agencies. In one study agency A had repeatedly reported that agency B was active in a case, but ultimately the investigator learned that agency B was not actively involved.

Paths to coordination

This does not mean to imply that collaboration is a poor idea, but rather that if the value is to be tested and the benefits reaped collaboration must really exist. It also means that the problems of coordination and collaboration must be recognized and faced sooner and more clearly than often happens.

To combine, to coordinate, or to integrate programs involves different kinds of processes. There are those who believe, with Alfred Kahn, that only a comprehensive and integrated network of services will meet the needs, and that this cannot be achieved by putting together a patchwork of already existing activities.¹² However this may be, in the immediate present many communities find it more feasible to attempt a welding of agencies and services already existing than to reorganize them entirely into a new multipurpose, multiservice organization. I have no prescription for success in such efforts. Each com-

munity that attempts to coordinate services will have to solve these problems in its own way according to its own circumstances.

A number of projects aimed at coordinating services have produced gratifying results, sometimes by coming to a workable administrative arrangement through trial and error. But a number have foundered through failing to establish a workable administrative setup in advance. The habit of emphasizing the positive in reports robs initiators of new programs of the opportunity to benefit as fully as they might from the lessons learned by others.

Some essentials

Three points especially have been brought home to me in reviewing project reports and proposals:

1. Although it may be desirable for some communities to set up new, multiservice programs, for others it will be more realistic to build on existing resources than to try to create a large, new network of services with an independent structure. A challenging imperative for the latter is to facilitate innovation within existing agencies and organizations, to open up inviting and feasible pathways to change.

2. Some kind of centralized administrative authority is essential. One of several possible ways to achieve this would be by an administrative agent—a director general—operating outside any constituent agency. That is, rather than selecting one of the cooperating agencies or departments to exercise final administrative authority, the cooperating group would designate a person to coordinate the activities of all. This person would need both program experience and administrative know-how. The experience might have been gained in one or more of the cooperating organizations, but for the duration of his appointment he would be outside any constituent agency.

One would hope this director general would not be an evangelist of any single administrative faith, be it group dynamics, management counseling, or Yoga, but would have some familiarity with the relevant principles that have been found useful in welding together diverse disciplines and people—drawing these principles from any field and any experience that have developed them.

3. Whatever administrative plan is set up must be worked out very carefully in advance, with realistic recognition of the kinds of problems that are inevita-

ple in such an undertaking. What and how serious these problems are probably cannot be learned from the printed page. Full anticipation can come partly from experience and partly from picking the brains of people who have struggled with them. Someone could render a real service by systematically interviewing people who have been on the administrative end and those who have been on the practice end of programs designed to offer comprehensive services to unmarried mothers, as well as people who have been involved in other types of comprehensive services.

Continuing services

Another impression left by our review was that, for the most part, services designed for "unmarried mothers" end when the women they serve become in fact unmarried mothers—that is, at or shortly after delivery. A few demonstration programs—an increasing number fortunately—do offer help to such women in taking on the role of a mother, in learning to manage a household, and, if necessary, in earning an income. But, for the most part, services still focus on the prenatal and immediate postnatal period.

If services are to be truly comprehensive, they will have to serve unmarried mothers for several years after they actually become mothers.

It would not be feasible or sensible to try to transplant the Scandinavian pattern of service into this country. Yet in developing a system more satisfactory than the one we have—if, indeed, it could be called a system—we might profit from the Scandinavian experience. In Denmark, for example, an unmarried mother is given help in finding adequate living quarters, day care for her child, and education or vocational training for herself, sometimes for several years. According to reports more than 90 percent of the mothers so helped eventually marry and, presumably, establish stable homes.¹² The rates of births out of wedlock in Denmark are reported to have decreased in recent years. Without assuming a cause-and-effect relationship, one can still say that apparently the kind of help that opens up a vista of stable family life and economic independence does not increase such rates.

Because of the often-expressed fear that effective help for unmarried mothers might encourage births out of wedlock, it should be recognized that in this country also the scant evidence we have is all in the other direction. We have supplied ourselves over the

years with plenty of evidence that withholding services and support does not decrease such births. And the few relevant studies available show that giving services and support does not increase them. Births out of wedlock do appear to be increased, however, by programs that put a premium on fatherless homes by refusing aid to families containing an able-bodied man, regardless of his ability to support.

And what of prevention?

That last comment heads directly into the question I said I would skip: the question of prevention. And I will skip it, too, after explaining why.

We need to differentiate sharply between serving people who have problems and forestalling the problems. Service agencies should be able as well as eager to help those who have become pregnant out of wedlock and to help their children much more than at present. Possibly they can also reduce somewhat the frequency of repeated out-of-wedlock pregnancies. Some promising efforts in the latter direction are projects for helping teenage unmarried mothers to complete their high school education, for example, in Chicago, Detroit, and the District of Columbia.^{13, 14}

Educational and vocational competence cannot be guaranteed to reduce "recidivism," but lack of these achievements can be almost guaranteed to promote it. Nevertheless, according to some very convincing analyses, out-of-wedlock pregnancy is largely the result of social and economic forces that service agencies cannot be expected to control or even to modify greatly.

Many people were disturbed by the study report, "Girls at Vocational High,"¹⁵ which concluded that social casework services did not substantially reduce school dropout, out-of-wedlock pregnancy, and other symptoms of undesired behavior among the girls who received the services. But how can we expect individual or group counseling to counteract the tremendous weight of social and economic deprivations burdening these particular girls? When young people have been as deprived as were those who predominated in the study group, perhaps the desired results can be hoped for only after a couple of generations have been reared with adequate employment opportunity, adequate social respect, and adequate self-esteem.

But even then, years of social and economic rehabilitation might only open the way for response to the influences that affect a very different group of

unmarried mothers—the white and nonpoor, among whom rates may have risen faster in recent years than among the first group. With regard to the socially advantaged, a different set of social forces appear to be operating.

To discuss prevention of unmarried parenthood at this time, one would have to discuss our economy, including the consequences of poverty for the poor and the consequences of affluence for the rest of us. One would also have to discuss the values we talk about and the values we live by, the discrepancies between them, and the impact on youth of those discrepancies. One would have to discuss the effects of social and economic discrimination on Negro men, women, children, and families. One would have to discuss the effects of affluence, our current life tempo, and the status-success-money-popularity complex on all our young people.

It is appropriate to discuss all these subjects and a number of related ones. But it is not appropriate to hold our helping services accountable—or for them to hold themselves accountable—for changing the values and behavior patterns that our society has fostered and continues to tolerate.

With regard to prevention, I should add that whether dissemination of information and resources for family planning will perceptibly affect illegitimacy rates in the near future is a question not easily or categorically answered, even by demographic experts. However, there is strong consensus among its advocates that the encouragement of family planning is likely to enhance the quality of family life and therefore to be beneficial to all family members, married or unmarried.

In summary

I have been trying to establish several points, the chief of which are:

1. The increase in births out of wedlock has occurred chiefly because there are more people and not because the likelihood has increased that an unmarried woman will bear a child out of wedlock.

2. Even if illegitimacy rates remain constant, or even if they decrease somewhat, the numbers can be expected to continue rising.

3. To the extent that increase in numbers exceeds increase in services, the longstanding service gap widens; and it also widens as our ideas broaden about

the kinds of services that should be available to unmarried mothers and their children.

4. Efforts to coordinate and integrate different kinds of services represent a promising trend.

5. Such efforts have the best chance of success if they are preceded by concerted, extended, and realistic planning that takes account of the human and organizational problems involved in fusing the activities of separate, autonomous disciplines and organizations, and builds on the experience of others in similar undertakings.

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² Herzog, Elizabeth: The chronic revolution: births out of wedlock. *Clinical Pediatrics*, February 1966.

³ Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics: Monthly vital statistics report highlights, June 14, 1966.

⁴ Vincent, Clark E.: Unmarried mothers. The Free Press of Glencoe, New York. 1961.

⁵ Adams, Hannah M.: Social services for unmarried mothers and their children provided through public and voluntary child welfare agencies. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Child Welfare Report No. 12, 1962.

⁶ Winston, Ellen: Unmarried parents and Federal programs of assistance. Paper presented at the Northeast Area Conference, Florence Crittenton Association of America, Washington, D.C., Oct. 11, 1966 (Mimeographed.)

⁷ Bernstein, Rose: Gaps in services to unmarried mothers. *Children*, March–April 1963.

⁸ ———: Unmarried parents and their families. *Child Welfare*, April 1966.

⁹ Herzog, Elizabeth; Bernstein, Rose: Health services for unmarried mothers. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 425. 1964.

¹⁰ Gallagher, Ursula: Interprofessional teamwork to safeguard adoption. *Children*, May–June 1959.

¹¹ A guide for collaboration of physician, social worker, and lawyer in helping the unmarried mother and her child. *Children*. See p. 11 of this issue.

¹² Kahn, Alfred J.: Unmarried mothers: a social welfare planning perspective. Unpublished paper presented at the Northeastern Area Conference, Florence Crittenton Association of America, Inc., Boston Mass., Oct. 19, 1964.

¹³ Gallagher, Ursula: School age pregnancies: a view from Washington of a program of prevention and care. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966

¹⁴ Wright, Mattie K.: Comprehensive services for adolescent unwed mothers. *Children*, September–October 1966.

¹⁵ Meyer, Henry J.; Borgatta, Edgar F.; Jones, Wyatt: Girls at vocational high: an experiment in social work intervention. Russell Sage Foundation, New York. 1965.

a guide for
collaboration of
PHYSICIAN,
SOCIAL WORKER,
and **LAWYER**
in helping the
UNMARRIED MOTHER
and **HER CHILD**

The need for close cooperation between the physician, the social worker, and the lawyer in the care of the unmarried mother should be universally recognized. Each of these three is responsible for advising the unmarried mother of the need for consultation in her case with the other two disciplines involved, because each has a special field of competence. While recognizing that in some jurisdictions individuals, as such, may place or otherwise facilitate the adoption of minors, it should be emphasized, nonetheless, that physicians, social workers, and lawyers, individually or jointly, when acting as individuals and not in cooperation with a qualified child placement agency, do not have the facilities and resources necessary to provide protection and services needed by all persons affected by the adoption. To further this cooperation, the areas in which the primary responsibilities and those in which the function of the three disciplines overlap must be delineated.

The *physician* is held responsible for the physical and mental health of the patient. It is the physician

Physicians, social workers, and lawyers are the professional persons who in their practice most frequently encounter unmarried mothers. Where does the responsibility of each begin and end and how can they most fruitfully work together to best serve the needs of the unmarried mother and her child?

For the past 5 years the organizations that represent these professions, led by the American College of Obstetricians and Gynecologists, have been working with the Children's Bureau and the Child Welfare League of America to formulate an answer to this question. The resulting statement, presented here, was completed in the summer of 1966 and by the end of the year had been officially approved by the following organizations:

The American College of Obstetricians and Gynecologists
The American Academy of Pediatrics
The American Medical Association
The American Bar Association, Section of Family Law
The Child Welfare League of America
The Children's Bureau.

who must make the diagnosis of pregnancy, determine the expected date of delivery, and decide where the delivery should take place. Among other things he must decide how much information the patient should be given on the physiology and pathology of pregnancy, labor, and the puerperium. His decision on whether to advise the patient to nurse the baby (if she decides to keep him) will rest on emotional as well as physical factors.

He must safeguard the confidentiality of the information the patient discloses except as provided by the laws of his State. Recognizing the limitations placed on a minor, he must be certain of the validity of the consent the patient gives for any disclosures, treatment, or procedure. If social services are available, the physician should avoid becoming involved with the placement of the infant or acting as an intermediary.

The responsibility of the *social worker* includes helping the unmarried mother with the distinctive social and emotional problems connected with having a child out of wedlock. To this end, the social worker draws upon the experience of social agencies in working with unmarried mothers, upon familiarity with community resources, and upon social and psychological diagnostic skills in determining what help a particular client needs and can use. Among

other things, this involves referring the patient for early and competent obstetrical examination, emphasizing the need for continued antepartal and postpartal care, reinforcing the medical care by strengthening the faith of the patient in the doctor, and, where possible or necessary, implementing his recommendations.

The social worker counsels the patient on plans for her future and that of the infant, always safeguarding the best interests of the child. The social worker provides psychological help and support complementing that given by the doctor. The social worker recognizes and supports the legal obligations of the doctor as to the results of treatment or advice, including professional disclosures and the peculiar problems of a minor.

The social worker counsels the unmarried mother in the various social aspects involved and recommends that she consult a lawyer for advice on the legal aspects as needed in the individual situation.

The lawyer for the unmarried mother is responsible for counseling her regarding the legal consequences of keeping or of giving up her child and of her legal rights in respect to the putative father. If she releases the child for adoption, he must be sure that all legal requirements are met. He should not represent the prospective adoptive parents. If social services are available, the lawyer should avoid becoming involved with the placement of the infant or acting as an intermediary.

All three disciplines recognize the right of the unmarried mother to make decisions for herself and her child except where such rights are involuntarily terminated by court action. Likewise, all three recognize that each must give advice and guidance to her. Whether giving advice is limited to mere clarification of the alternatives between which the client must choose or extends to a firm recommendation for the course of action the patient should take, the collective counseling, like parental guidance, must be harmonious lest the unmarried mother become confused. Differences of opinion which may arise as to the advice to be given should be resolved by prior conferences.

Broad principles have been established through experience in all three professions, but philosophies vary in different communities and change from time to time not only within the same community but also within the Nation.

Furthermore, each case must be individualized,

particularly with reference to questions such as:

1. Shall the parent of the patient or the putative father be told of the pregnancy?
2. Shall the patient marry the putative father?
3. Shall legal action be taken against him?
4. Where shall delivery take place?
5. Shall the putative father visit the patient before or after delivery?
6. Shall he ever see the baby?
7. Shall the baby be photographed and the picture made available?
8. Shall the patient be allowed, urged, or forbidden to see her child, put him to breast, or care for him?
9. Shall the patient have psychiatric help; if so, to whom shall she be referred?
10. At which point in the pregnancy or puerperium shall the decision be made as to the child's future?
11. If the decision is for adoption, how and when shall final surrender of the child be taken?
12. Shall the mother be told of any deformity or handicap of the child and, if so, when and by whom?
13. If the matter of legal residence is involved and the possibility of nonadoptability, who shall be responsible for properly informing and counseling the unmarried mother?

When the doctor, social worker, and lawyer are mature, experienced individuals, each primarily concerned with working out the complex problems in any given case for the best interests of the child and the unmarried mother, each recognizing and respecting the responsibilities and competence of the other derived from professional training in dealing with the physical, mental, emotional, social, and legal factors involved, there rarely will be a difference of opinion. If such a difference does arise, one which cannot be resolved by a conference, genuine collaboration requires the wholehearted assistance of all three in supporting the judgment of the member of the discipline with primary responsibility, namely for the physical and mental health of the mother and child, the doctor; for the social and emotional welfare of the mother and child, the social worker; and for the legal protection of the mother and the child, the lawyer.

SOCIAL WORK STUDENTS

IN DAY-CARE SETTINGS

THELMA GOLDBERG

As day care is increasingly recognized as an essential child welfare service, it seems timely to examine the value of day-care settings for professional social work training. From the experience of a student unit that has been operating for the past 3 years in the Division of Day Care, New York City Department of Welfare (under a Children's Bureau grant to the New York University Graduate School of Social Work), I have been able to formulate some general principles about this type of fieldwork placement. Such principles must be general to be useful to social work educators planning fieldwork placements in day care, for day-care services are offered under many different kinds of auspices and embedded in a great variety of settings.

As the many types of services needed by culturally deprived preschool children are developed, the role of day care as a preventive child welfare service becomes clear. Too often child welfare services operate "after the fact": the family is already separated, and the focus is perforce on the child away from his natural family. Day care offers a rare opportunity for testing, in the observance rather than the breach, those child welfare principles that stress the importance of the child's own home. This focus on the family goes beyond the traditional appreciation in the field of early childhood education of the importance to the child of the parent and the home. The basic distinction between day-care services and nursery and other programs for preschool children is the focus in day care on the needs of the entire family and its economic, physical, and emotional burdens—a focus that may at times result in classroom groupings, hours of care, or other conditions not optimal for the child from an educational point of view.

What do we hope to prevent by offering day care

for children? In extreme instances, we hope to prevent placement of children out of their own homes; in other instances, we hope to prevent subtler erosions and impoverishments of family life under social and psychological pressures. Here, surely, is a goal consistent with the basic ethics and values of professional social work.

However, evidence of social work thinking in the day-to-day operation of a day-care service is often sparse. In few instances has social work contributed its full share to the day-care center team in an integrated fashion. The profession is often represented by a single, overburdened worker who can rarely go beyond the demands of intake and emergency referral services. As in many child welfare settings, most social service staff members of day-care centers are not professionally trained. Only occasionally is there a sophisticated social work consultant available to staff members or parents even on a part-time basis.

In a fieldwork placement in a day-care center, this situation presents a problem for the students' supervisor, who must very actively serve as a professional model as well as a teacher and must continuously plan and intervene in the students' experiences in the centers. The paucity of the social work staff also means that sometimes new dimensions in service are being explored in the agency only by the students. Thus, special delicacy is called for in balancing service responsibilities and learning opportunities.

The supervisor must shape the student's caseload if the potentials for learning are to be tapped, but he can do this flexibly according to his own and his students' professional proclivities. For example, the day-care center provides opportunity, depending on the particular situation, to place more or less emphasis on the ways the center and its clients are

involved with the community, on work with parents' groups, on concentrated observation of the children and collaboration with the preschool teachers, or on casework with members of the child's family.

Uncovering needs

To the incoming social work student, the members of the center's educational staff may appear to be the backbone of the service; his first major task is to clarify his own role for himself, for them, and for the families being served.

Frequently, a family that needs help from the community in the care of its young children may be in need of other kinds of service as well. Yet, unless this comes out clearly at the time of intake, the parents may view the center as child oriented and "not interested in our other troubles," and the newly arrived social work students may be overly fearful of violating family privacy by offering service that has not been explicitly requested. But, as they come to feel more at home in the center and become more inventive in making themselves visible to the children's parents, the students uncover a wide range of needs and reactions. At one end of the range they find parents who are eager to avail themselves of social service and unable to get to an appropriate resource. For example, there was—

Mrs. M, a working mother with seven children, who had been seeking help with marital problems and also service for an acting-out, preadolescent child. Because of a complex schedule on her job and the lack of services in or near her neighborhood, she could not get the help she needed until a social work student at the day-care center offered to discuss her problems with her at the time when she came to pick up her children. She was one of the first persons to request regular casework appointments, and she used them productively throughout the year.

A variant of this help-seeking client is the isolated or fearful parent who finds casework help more palatable if it is made available in a familiar ego-supportive setting in a way that enables him to drift into it at his own pace. Many such parents begin with occasional, irregular appointments with the social worker and move on later to planned regular contacts; they may need to test the relationship with the social worker for comfort and viability.

At the other end of the range, the students find families who are not seeking service, actively or passively, but who obviously are beset with many problems, often including child neglect or abuse. These unmotivated, disorganized families in many ways resemble those found in a protective services caseload.

With them the student is plunged into experimenting with the reaching-out, "aggressive casework" techniques that have been receiving increasing attention in social work. Their concern about violating the principles of self-determination and their desire to minimize and get beyond rejection make for considerable discussion and debate with each other and with their supervisor.

The students, however, tend to feel isolated if these issues are discussed only at the agency. "Catching" a caseload, defining one's professional role and goals, and thinking through one's basic philosophic stance are demanding experiences. More thought needs to be given in the schools of social work to ways of modifying the curriculum so that what students learn in the classroom will mesh more closely with the experiences they are having in this and other new types of fieldwork placements. Perhaps more use could be made of the case material as it is fed back into the schools.

As time goes on, the students do make many productive contacts with some of these "hard-to-reach" families and they find this a most rewarding experience. (Some students have found the experience a valuable foundation for later work in community psychiatry programs.) At times, too, because their caseloads are small, students can pick up on the less obviously critical needs of a family in crisis.

Mrs. P's young children had been brought to the day-care center when their mother, in a suicidal depression, had applied for admission to a mental hospital. The social work student observed that a 14-year-old daughter was taking on an increasing number of responsibilities and spending nearly all of her time with her mother. She seemed to be taking over the husband's role with the mother and the mother's role with the younger children, while unconsciously avoiding facing her own academic retardation and isolation from her peers. The social work student helped the father become more directly involved in planning; arranged for a temporary homemaker to go into the home; and offered the girl casework and tutorial services to enable her to pick up the threads of her own life again.

A unique opportunity

The day-care caseload, thus, is in some respects an educational smorgasbord. It offers students of social work some learning opportunities similar to those in the family, child welfare, and child guidance services, as well as the kind of learning opportunities found in authoritative or crisis-oriented settings. What does day care offer that is special and unique? An unparalleled opportunity to observe young children in depth and over a long period of time!

Many social work educators have long felt that the social work curriculum lacks sufficient content in child development and behavior and that the little that is taught in this regard is presented in a fashion that is almost exclusively theoretical. However, in a day-care center, social work students are intensively exposed to the young child in action, alone and in the group; they learn intimately the meaning of "ages and stages"; and they are confronted with the subtle ramifications of child-adult relationships. In such a setting they can observe at first hand the interactions between family members and the effect of familial, cultural, and class styles of child rearing on individual children.

A child's reaction to separation from his parents becomes much more than a textbook concept when one watches children newly admitted to the center, the last child to be picked up in the evening, or the mother who is herself fearful of leaving the support of the center as her child approaches school age. To see a 3-year-old child weep for mommy at nap time but turn his back on her in mock absorption with a toy when she comes for him in the evening; to watch a fatherless boy repeatedly play grownup in a man's hat; to notice a parent's mixed reactions to his child's growing mastery of a language he does not speak or his envy of the care the child receives; to see evidence of the insatiable yearning of a 4-year-old child in his clinging response to the teacher who takes him on her lap—each of these everyday experiences in a day-care center brings the real meaning of a theoretical concept home to the student.

At times the student may work directly with a group of children or an individual child in the center; he will not be in the position of talking to a parent whose child he has never seen. This aspect of the placement, combined with more frequent home visiting than is usual in other types of fieldwork placement, makes for a three dimensional view of

family life. With this perspective, the student can more readily recognize the effect of special circumstances. For example:

Mr. L applied for day care for his 5-year-old child after the sudden death of his wife. He had not told the boy of the death and felt the child was little disturbed by it. However, the social work student noticed that in the classroom the child showed increasing preoccupation with fantasies of destruction and disappearance; signs of depression; phobic clinging to a motherly teacher; and "irrational" expressions of rage against the father.

* * *

Mrs. S complained that the hospital treating her son for a mild case of cerebral palsy had decided that, despite his excellent adjustment to the day-care center program, he could not enter a regular first-grade class because of a speech handicap. Watching this child in the group, the student saw signs of unusual compensatory devices in him. He was extremely cheerful and outgoing, reached for help as he needed it, ignored rebuffs and teasing, managed to communicate despite his speech problems. Therefore, the school guidance counselor was invited to observe the child at the center and to evaluate his functioning. As a result, the school admitted the child to a regular class.

Teacher and social worker

In any day-care service, a large percentage of referrals for social service directly involve the well-being of children in the center. Teachers naturally try to speak to the parents directly about the things that worry them, often in an effort to help parents modify their handling of the child. But many parents are so emotionally deprived themselves that they themselves must be "fed" before they can feed their children; their own worth must be affirmed; they, too, must be helped to have fun. Some parents see young children as extensions of themselves and so cannot mobilize their parental strength unless their own patterns of functioning and their own individuality are recognized. Fortunately, in most day-care centers I have known, staff acceptance for parents is genuine, and fruitful collaboration between teacher and social worker takes place.

Mrs. Z was referred to the student social worker by the teacher because she seemed unable to pick up her children on time or to feed and clothe them appropriately. Mrs. Z was a 24-year-old divorcee with four children. She was described by the teacher as gay and impulsive, unable to control the children, "a big kid herself." She had been known earlier to a family agency, which had "talked her out of placing the children."

In her interviews with the student, Mrs. Z quickly revealed, under her gay façade, feelings of depression and worthlessness, a sense that no one cared for her except as the mother of her children. As the teachers and director continued to point out to Mrs. Z her maternal responsibilities, the student focused Mrs. Z's attention on her own needs and aspirations

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and helped her look into the reasons why she needed to invite social disapproval. When the student's fieldwork placement in the center ended, Mrs. Z accepted referral to another agency for continuing casework service. Said she: "I needed a social worker to chase me."

Mrs. Z's case illustrates the value of spelling out the differences in the roles of the teacher and the social worker in relation to a particular client. Collaboration is possible only when each party understands the special contribution of the other and the effectiveness of each is enhanced by a team approach. Learning what teachers can offer and how to communicate with them in the best interests of children and families is an important part of the social work education that takes place in a day-care setting and one that will be useful to the student in future professional functioning.

Finally, a word must be said about two important aspects of the social work process that students can learn to master in a day-care setting: (1) the appropriate application of diagnostic thinking; and (2) inventiveness in the use of social resources, including one's own agency. In a day-care center these processes are clearest in the period of intake study and in the "reviews" to determine what use is being made of the service.

Miss J applied for day-care service for her 3-year-old daughter, who had been born out of wedlock. The child was exhibiting bizarre traits in speech and character and seemed to be reacting to an extremely confused pattern of living. A careful intake study produced a great deal of evidence that Miss J was psychotic and very much afraid of being referred for psychiatric help. She had ambivalent feelings about having applied for day care, for she was afraid both of being scrutinized by other people and being separated from her child.

It was decided to try to support Miss J by admitting the child to the center and so exposing her to some healthy influences. Upon admission, the little girl proved to be not too damaged to respond to staff members and to the other children and quickly made great developmental strides. The student helped the staff understand the mother's condition so that demands in excess of her ability were not placed on her.

* * *

Mrs. W applied for day care for her two children on the basis of her need to work to supplement her husband's income. Soon after the children's admittance, however, she lost her job and for a while thereafter seemed to be avoiding the members of the center's staff. The teachers suspected that she was being punitive toward the youngest child, who at the same time was being overindulged by his father. The student arranged for an interview with Mrs. W and told her that her loss of employment did not affect her eligibility for the center's services. Mrs. W appeared relieved; she indicated that she was preoccupied with a serious marital conflict she did not wish to discuss and that she wanted her children to remain at the center primarily to protect them from her own stormy feelings.

Eventually Mrs. W asked for counseling service to work out plans for herself and the children following a long-threatened separation from her husband.

What can be distilled as the essence of a student's experience in day care as compared to fieldwork placements in other settings? Certainly the fact that the student obtains entrée to the family by means of involvement with their young children affects the quality of the experience. As we have seen in such a setting, parents may initially be reluctant to discuss their negative feelings toward a child or may need to test the genuineness of the agency's interest in themselves and their older children. However, most families seem to approach the day-care center in an aura of hopefulness, as though the opportunity to send a young child into the larger community for the first time were providing them with a second chance. This hopefulness, coupled with the relief from stress the concrete service provides them, may make them more accessible to social work intervention on many seemingly unrelated levels of experience. For the same reason, families whose children are no longer in a day-care center may return to the center in times of trouble; it tends to be invested for them with the feeling that a fresh start may be possible.

I think there are two crucial ways in which social work students are touched by an experience in a day-care center. The first comes from operating in a setting in which their profession is in the minority. To function, they are forced to examine and to articulate, in a direct and personal way, what it means to be a social worker, how a person goes about being one when his service has not been requested by the client, and how he explains what he does to his colleagues from another discipline.

The second crucial way in which social work students are touched by an experience in a day-care center can be observed in how they react to a children's shelter or a foster home program or to a theoretical discussion of children's needs. Whatever their own backgrounds and preconceptions, regardless of their particular caseloads, the social work students in day care unanimously seem to have a deep and burning conviction of the irreplaceability of the child's own family, flawed and idiosyncratic though it may be, for the young child. In these times when the importance of his own family to the child often seems mentioned only as a half-hearted cliché, ignored in program planning, an experience that brings it home so vividly to social workers at the start of their careers would seem to merit a place in professional education.

A GROUPWORK APPROACH IN

CROSS-CULTURAL ADOPTIONS

CONSTANCE RATHBUN ● RALPH L. KOLODNY

● "The love and attention of two new parents and the influence of many playmates here in Massachusetts are turning an active little Chinese girl into an active American."

In these terms a Boston newspaper describes the adoption by a Caucasian couple in New England of a child from an orphanage in Hong Kong. Behind this statement are a series of problems in interracial adoptions, often thought about by social workers but only infrequently subjected to careful scrutiny. From the perspective of the community, the experience may be regarded as a "humanitarian adventure" in which there is much sincere interest. From the adoptive parents' perspective, however, it represents a procedure that poses a host of dilemmas.

Of primary significance in the creation of these dilemmas is the shift in the adopted child's role from that of one child among many similar children in an institutional setting overseen by one woman to that of a child in a family with her own father, mother, and brothers and sisters. Of equal importance is the radical change from ancient Chinese to contemporary American rules of conduct. These transitions, moreover, have to be made by the child in a society ambivalent toward racial mixture. The child's adoptive parents are in the unique position of having to prepare their oriental child for the status accorded a member of a minority group while simultaneously attempting to help him become emotionally a part of a family that is part of the dominant majority.

These special child-rearing problems apparently do not immobilize most of the adoptive parents. What followup reports we have of this type of adoption in most cases do not suggest severely pathologi-

cal adaptations either in the child or the family.¹ One can assume, however, that such problems engender tensions that must be expressed and dealt with if the adoption is to be a really positive experience for all concerned.

The kinds of tensions that arise in such families and the kinds of problems that worry the adoptive parents have been brought out clearly in the group meetings of five sets of adoptive parents of five pre-adolescent Chinese girls who came to this country from the same orphanage in Hong Kong and were placed for adoption by the Boston Children's Service Association. All of these parents had children by birth as well as by adoption and had been the subjects of a home study and casework service before the adoptions became legal.

The discussion group was initiated shortly after the children's placement and continued for many months after the adoption decrees had been granted. It was formed and led by Carol A. Jenkinson, a member of the agency's groupwork staff who met with the group at the agency's office for more than 2 years. During this period, the group held ten 2-hour sessions, the rather wide spacing of meetings having been dictated by problems of distance and New England winter weather.

Age-related problems

One would, of course, expect parents of girls on the threshold of adolescence when meeting together to discuss their perplexities about this stage of development and their methods of coping with its crises. Our group was no exception. The parents expressed concern about ways of dealing with the normal nega-

tivism of this stage, about ways of helping a girl accept a more feminine role without encouraging her to act out sexually, and about methods of preparing a preadolescent girl for menstruation. These issues came up early in the group's existence and continued to appear, disappear, and reappear with varying intensity. As they discussed such subjects, the group sometimes sounded like any other group of parents of pubescent children.

A major task of preadolescence is the transition from the sexually latent orientation of the preadolescent years to a clearer heterosexual identity. This appeared as a theme in an early meeting.

Mr. J turned to Mr. W to say how much Bunnie and his son had liked Jill. His son particularly had talked about nothing else except Jill ever since she'd been there. Mr. W said Jill made a hit with the boys as a "boy" still, and not yet as a girl. Mrs. J said she thought Jill had shown a bit more interest in clothes than she had the last time she'd seen her. Mrs. W said she guessed that Jill really was all girl but that right now it still seemed as though she wanted most to be a boy. Mrs. W said she hadn't given up hope, however, that Jill would soon develop into a girl as her shape was already changing and there were lots of other signs of her growing up.

Thus, the group as a kind of "affective forum" freed the parents to express their concern about the many facets of preadolescent sexuality that might otherwise have not only been concealed from others but also from themselves. The many reactions to the issues discussed provided each parent with a perspective within which he could begin to assess his own reactions differently. In the meetings any attempt by any set of parents to cope imaginatively with the problems of their youngsters generally received support from the group.

Impact of cultural duality

However, the normal growing up problems of these children were not the problems that monopolized the group's attention. Whatever their temporary confusion over how to respond to problems of emerging sexuality and independence, these parents obviously felt confident of their capacity for helping the children weather the normal stresses of this stage of development. Their greatest concern has been over the implications of the children's dual cultural heritage and their "different" racial background.

In talking about the children's transition from group life in China to family life in America, the parents at first stressed only how smooth this had been and how skilled the agency had been in deter-

Both Constance Rathbun, left, and Ralph L. Kolodny were on the staff of the Boston Children's Service Association when the observations reported in this article were made, Miss Rathbun as director of casework and Mr.



Kolodny as director of groupwork. Miss Rathbun is presently director of research and special instructor at the Simmons College School of Social Work, and Mr. Kolodny is associate professor at the Boston University School of Social Work.

mining which child should be placed in which adoptive home. They admitted the children had experienced some difficulties in respect to language and food, but said these had soon disappeared. At the first meeting the J's, for example, could not get over "how well Bunnie had been matched to them"—happy and loving, she trusted everyone. The other parents nodded affirmatively.

At the second meeting, however, some of the anxieties that had been so carefully hidden when the group members first met each other began to emerge. They were expressed guardedly, but still with a great deal of feeling. The children, said the parents, had been displaying some ambivalence about their new names. The parents found this disconcerting, but were more worried about the fact that when under stress some of the children occasionally would go into a kind of hypnotic state. For example, the O's daughter, Le Ming, had responded with extreme withdrawal when Mrs. O had taken a cake to her class at school. Jill had reacted in a similar way when she had suddenly hurt herself. The parents of these children felt helpless in not knowing how to reach either child in this "trancelike" state.

Later on in the meeting, the group talked about the fact that each child had had to find her own way of adapting herself to the institution in Hong Kong and now was having to readapt herself to an American family. The group worker pointed out that Mr. E had spoken in their previous meeting of his feeling that Nancy had to be almost too good in order to feel that they would accept her. Mrs. W said that maybe this was true of Jill who, in a way, also had to be too good. The questions then arose as to how secure the girls did feel and how confused they might be. The girls had visited at each other's homes at Christmas time, and now each of them was

calling all of the men "Daddy." This confused response occasioned considerable distress on the part of the "daddies," and led all of the parents to question whether the children would ever separate emotionally from their "family of origin"—the orphanage "family" in Hong Kong.

The worker wondered if the children even knew what it meant to have a family—to be a part of a small family with a mother and a father and with only a few siblings. Mrs. E said immediately and emphatically that she did not feel they understood this at all and that she and her husband felt their task was to educate their daughter to what a family was.

Mr. O said that Lo Ming may be a little bit more aware than the other children that she now had a family of her own. However, both he and Mrs. O said that they had to tell Lo Ming over and over again, in no uncertain terms, that they were her parents and that she was there to stay with them.

The group agreed that probably all of these children still had tremendous fears about whether or not they were really here to stay, and that it was pretty frightening to the youngsters to have a close relationship with parent figures now, particularly with a father. Mr. O said that Lo Ming had spoken of her father before she came to America as being "Jesus" and now she had two fathers—Jesus and Mr. O. Mr. E said he was sure that Nancy did not really know what a father was. He said he was really puzzled about whether or not he could educate her to understand what a family really was, and he wondered whether or not any of the children would ever really be able to become the adoptive parents' "own."

This was the first time that we had indications in the group of the feeling the parents might have about whether or not they ever could accept themselves as parents of these children or the children accept them as their parents. Mr. W said that probably the children never would be the same as their own children for, after all, their own children were white and these children were oriental.

Having found that the agency worker was not upset by their confusion and tension, the parents began to wrestle with the issue of how to help the children become "their own" without completely sacrificing the children's previous identity. They spoke of the role of the Chinese language in the children's present life. This led to some questions: Should or should not the parents search for a Chinese tutor to help the children keep up their Chinese? Should they take the children on visits to the parents' Chinese friends or not? If they did, would it demonstrate to the children how much they could love little Chinese girls? (Lo Ming had given some indication of feeling she could not be loved because she was Chinese.) What should they do if the child rejected reminders of her Chinese heritage? Do most of the schoolmates of these children regard them as potential companions or as mysterious

"racial strangers" to be kept out of their peer groups? Does the behavior of schoolteachers toward the children reflect real acceptance?

As they looked more directly at the tension under which their adopted daughters were functioning, the parents began to discuss their confused ideas and negative feelings about the social milieu in which the girls had lived in Hong Kong. They told about puzzling reports from the children of some "sexual events" in the orphanage. It was difficult to determine what had stemmed from the children's very vivid imaginations and what had actually happened. The parents had at first been impressed by the sheltered nature of the children's life in an institution run by an all-powerful "mama." Now, having listened more closely to what the children were saying, they began to wonder whether sexual sophistication rather than naiveté had characterized their pre-American life.

Mrs. O, recounting a story Lo Ming had told her, wondered if the other families had heard about the "accident" that had taken place somewhere in Hong Kong, something involving a man and a woman in the nude. . . . Mr. and Mrs. W looked at each other with knowing eyes. . . .

It seems that Jill, the W's adopted child, at one time became very upset and told them she had had a bad dream. She had then referred to an experience in Hong Kong where some boy, and it was not clear who this was—whether the gardner, someone else, or a mythical person—had actually come to her room when she was in her bunk and had told her to take down her pants. She had become very much upset about this and had evidently screamed.

There was a question, as we looked at this, as to how much of the tale was real and how much of it was based on the fears and questions of a girl who knew too little about sex. The parents expressed some question as to how naive their children really were and said that they really did not know what had precipitated this type of story.

Facing marginality

Whatever their feelings of confusion and, perhaps, dismay over the possibility of their adopted daughters having had sexual encounters of some sort in Hong Kong and their concern about what this might mean in relation to their future behavior, the parents were now ready to consider the less "rosy" aspects of their relationships with the girls. In the group they apparently derived enough support from each other to bring into the open still more worries and areas of confusion. They now began to talk about the implications of the girls' racial "difference" for their heterosexual and general social relationships. Either the parents had not thought about this ques-

tion previously or had been blocked by anxiety from freely discussing it. By their sixth meeting, however, they were showing openly—though some at the same time denied it—their worry over the social marginality of these children and their fears lest the girls be left suspended in a kind of sociocultural limbo.

Mr. W said he worried about what would happen to his adopted daughter if war with China should occur. Mrs. J said, "I'll cross that bridge when I come to it," but she expressed unhappiness about the more immediate experience of seeing people stare at her daughter in restaurants. Mr. W said the hard thing to take is the fact that the children are not really accepted by the Chinese community here. "The Chinese don't like it at all because we have adopted their children." Mr. J said he and Mrs. J had not had any experience that gave them such an impression, and Mrs. A said that she had not either. Mr. W said he and his family had felt a kind of coldness when they went to a Chinese restaurant or to Chinatown and that some Chinese people had told him that they did not see why white people would want to adopt Chinese children and doubted whether the children could really be Chinese anymore.

Mrs. J said she had thought about enrolling Bunnie in a Chinese school so that she could keep some of her Chinese cultural background, but Mr. W said that the school would probably not accept Bunnie because she did not live in a Chinese family.

When Mrs. J asked the worker whether she thought the Chinese school would accept Bunnie, the worker replied that she did not know and then asked Mrs. J why she wanted to have Bunnie continue with Chinese. Mrs. J replied that she did not want Bunnie to lose her cultural heritage, but added suddenly, "But you know Bunnie seems more English than Chinese" because the orphanage "mama" had brought the children up that way. She said she did not know what would be best for Bunnie, but she felt that Bunnie would become all American eventually. . . .

Mrs. J then said that Bunnie had often spoken to her of the fact that she had three mothers—her own mother, the orphanage "mama," and now Mrs. J. She did not feel that Bunnie was at all confused about which mother was which and about what her relationship had been with each. She felt, however, that Bunnie was curious about her background and should be helped to know more about it.

Mrs. A said that her adopted daughter, Cathy, occasionally asked whether she could grow up to look like her "mummy" and to be an American. Mrs. A said she always told Cathy that she was a very pretty little girl and would grow up to be a very pretty Chinese lady.

Mrs. W said that she usually forgot that her two adopted daughters were Chinese, for they seemed so American to her in all of their ways. Her husband agreed but added that they did worry sometimes, especially about what would happen when the girls reached dating age. . . .

Each parent advanced his own notions of how to cope with these problems. The worker did not press

them for consensus as to the best way of coping, but helped them provide each other with a series of alternatives that could be adapted to the particular circumstances of each child.

The J's eventually made the decision to send their child, Bunnie, to an afterhours Chinese school. The other parents then questioned them eagerly about Bunnie's experience there. The J's main purpose in sending the child there was to help her "realize the good parts of her Chinese background." Bunnie's major investment in going was more personal—this was a wish to keep the tie to her Chinese sisters in Hong Kong and to deepen her friendship with the Chinese minister's son, who is a fellow student. She enjoyed the school and, in contrast to her earlier position at home, was willing to be called by her Chinese name there, since all the students had both a Chinese and an English name.

Not all of the parents saw the Chinese school as a solution to the integration of the children's disparate strands of cultural influence. And they all still wrestled with the basic question: the degree to which these children would forever be Chinese. This came out in references to the children's appearance as they grew older. Would they be just "pretty ladies" or "pretty Chinese ladies"? "Would they be able to marry whomever they loved, regardless of race, or could a happy marriage result only if the alliance were with another Chinese?"

Disguised racial hostility

The parents exhibited a remarkable degree of frankness in their discussion of these questions. Then the latent and previously quite repressed racial hostility of one set of parents found expression in rationalized form.

Mr. and Mrs. A went on to give examples of the ways in which they were reminding their daughter that she is Chinese. Mrs. A said that unconsciously people used rather derogatory remarks about Chinese people in general conversations. They were sure their daughter would run into this as she grew older. They felt they owed it to her to prepare her for this, so that when she grew up she would not think people would just be mean to her but she would understand that some seemingly hostile remarks were just casual conversational idioms—just as when people say "that's Greek to me" when they cannot understand something.

Mr. A then said, "Yes, like people say 'crazy as a Chinaman,' or use the term 'chink' quite often." Mrs. A said they frequently use such phrases themselves around the house so that their daughter would know first that they could be made by people who loved you and were not meant to be derogatory. . . . Mrs. A again spoke up saying she was sure that her

daughter understood why they did it. Mr. A told of how he unconsciously had made some remarks about Chinese people to a group of young people in church and then had suddenly realized what he had said and looked at his son who was present and realized that he, too, was very conscious of the *faux pas* his father had made.

Many of the anxieties evidenced by these couples, as we have seen, were similar to those that might be felt by any parents who adopt older children. One would expect dating and marriage, for example, to be in the forefront of much of the discussion. However, such worries took on a somewhat more urgent character than usual among these parents. As do all couples who adopt older children, these couples were trying to follow two somewhat contradictory paths simultaneously—to find ways to help the children achieve a satisfying integration into their own family patterns and to prepare them for the adolescent's task of separating from a family not yet wholly theirs. The separation, however, was having to be accomplished in a social climate that made the parents unsure of the future attitudes of the community toward the children because of their ethnic origin.

Method and effects

The members did not receive advice from the group worker, nor from each other, on how to deal with these issues. Such issues will, no doubt, continue to trouble them in varying degrees as time goes on. Nor did the groupworker explore with the members any of the unconscious sources of their feelings about the issues they were concerned about or attempt to induce insight into the deeper veins of ambivalence that are always present in interracial adoption.

Rather, the groupworker helped each member to listen to the other and, in so doing, to listen to himself and thus to face honestly the problems bothering him. She gently countered the parents' tendency to deny the existence of such problems by conveying to them her feeling that the problems could be managed and a viable parent-child relationship created; that, while this relationship might be "strange" in some respects and at times not without some unpleasant components, it could be nurtured and bring increasing gratification; that fears and tensions need not be covered up in the interests of preserving family harmony; and that expressing and considering them in a group of persons in a similar situation could help strengthen the foundation of such harmony.

It is difficult to describe precisely the effects of this group experience on these adoptive parents. In the beginning we did not ourselves have any completely formulated notion of how they should use the group, although we were convinced that it would give support to their attempts at effective parenting. However, we do have evidence that their feelings toward the agency and toward their role as clients of the agency changed as a result of their participation in the group.

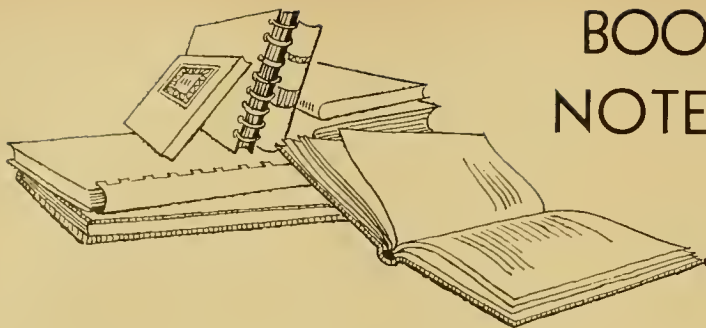
Initially the group members saw themselves as contributors to the agency, helping with its research into the workings of interracial adoption. Although based in fact, this attitude contained an element of defense against exposing themselves. Very soon it became clear that the parents were beginning to perceive the meetings as a means of supporting each other's efforts to cope with the many problems of adjustment they and the children were facing. No longer did each couple feel alone in struggling with a unique dilemma. To be able to talk about their anxieties with each other, with the catalytic help of the groupworker, gave them a healthier perspective from which to approach the task of building a stable family unit.

Testimonials by group participants are always slender reeds upon which to lean for evaluation, yet we cannot help but assign some degree of validity to them. The following entry in the record of the group's 10th meeting gives an example of a participant's own feeling about the group.

Mrs. J said she'd like to talk about something else. She had met another family who had adopted a Chinese child and this family envied them for having a group. . . . She thought all adoptive parents should be in a group with other parents, at least the first year they have the children. The others agreed this would be helpful. The worker asked why they felt this way. Mr. J said, "You think you are the only one with problems in the beginning and you are not so sure you ought to admit them even to yourself, but when you know others feel the same way it helps."

Only a later followup will test our interpretations of the meaning of this experience to these parents. We do know, however, that in the midst of their dilemmas and, possibly, second thoughts about the interracial adoptions in which they have involved themselves, these parents genuinely feel they have been helped by the group experience.

¹ Rathbun, C.; Bennett, C.; McLaughlin, H.; Garland, J. A.: Later adjustment of children following radical separation from family and culture. *American Journal of Orthopsychiatry*, April 1965.



BOOK NOTES

THE EMPTY FORTRESS: infantile autism and the birth of the self. Bruno Bettelheim. The Free Press, New York. 1967. 484 pp. \$9.95.

Many childhood psychoses, particularly infantile autism, can be traced to the child's conviction that his life is in mortal danger, according to the author of this study of infantile autism. He maintains that autism results from a breakdown in communication between the infant and others caused by overwhelming anxiety: the child reacts to a seeming threat to his life by not acting at all.

From the findings of 20 years of work with several hundred children at the University of Chicago Orthogenic School, the author describes specific childhood aberrations, the development and distortion of the personality in infancy, and the progress of therapy with the autistic child. He includes three detailed case histories of extremely autistic children.

The author also takes up the subject of the feral child and argues from illustration that "wolf children" are probably autistic. In the book's final section, he discusses the findings and opinions of other psychiatrists and psychologists on the nature and origin of infantile autism.

DELINQUENT CHILDREN IN JUVENILE CORRECTIONAL INSTITUTIONS: State administered reception and diagnostic centers. Compiled and edited by William E. Amos and Raymond L. Manella. Foreword by James W. Symington. Charles C Thomas, Springfield, Ill. 1966. 159 pp. \$7.50.

Through 10 experts in the correctional field, this book describes the resources and services of the reception and diag-

nostic centers for delinquent children. 12 States were operating in March 1965. The contributors discuss the history and philosophy of the centers; their use of psychiatry, psychology, and social work in diagnosing each child's problems; the contribution of teachers, researchers, and court officials to the work of the centers; and the design of the physical plants.

The editors point out that the success of the centers depends on interprofessional teamwork. They maintain that State governments must take the lead in combating delinquency because city and county governments cannot provide the statewide facilities, services, and programs needed. And they express a strong belief in the need for reception and diagnostic centers and in their potential for helping control juvenile delinquency.

FERTILITY AND FAMILY PLANNING IN THE UNITED STATES. Pascal K. Whelpton, Arthur A. Campbell, and John E. Patterson. Princeton University Press, Princeton, N.J. 1966. 443 pp. \$12.50.

About 92 percent of the 3,322 wives involved in the 1960 study of birth expectations and family planning on which this book reports said that they and their husbands wanted from 2 to 4 children and that they preferred to have them early in marriage. Though many couples planned to delay the use of contraceptives until their families were "complete," 87 percent of the wives said they had used or planned to use contraceptives at some time. Despite the delay in use by many couples, the authors found the number of couples who used contraceptives was much higher in 1960 than it had been in 1955, when they had made a similar study.

Education, socioeconomic status, religion, and race made a difference in the number of children the wives expected to have, the authors point out. Those with little education, in low-income groups, or who were Roman Catholics expected to have more children than others. Within the Catholic group, however, those in middle income groups expected to have fewer children than those in the lower and upper income groups. Nonwhite wives in the South expected to have more children than white wives, a difference not indicated in other regions.

The authors also discuss the wives' responses to questions about such subjects as fecundity impairment, methods and effectiveness of contraceptives, and the timing and spacing of births.

CULTURE IN AMERICAN EDUCATION: anthropological approaches to minority and dominant groups in the schools. Ruth Landes. John Wiley & Sons, New York. 1965. 330 pp. \$7.95.

This book reports on a project conducted by the Claremont Graduate School, Claremont, Calif., from 1959 to 1961 under the direction of the author, a cultural anthropologist. This project brought together education, social work, and anthropology to help teachers find ways of meeting the needs of children from backgrounds "different" from those of most American children.

During the experiment, teachers and school social workers from public schools in the area were shown how to adapt their methods and to adjust their goals to differences in the cultural backgrounds of children from such minority groups as Mexican Americans and Negroes, the author points out. The teachers were led to see how group customs "channel human energy" and how to tap this energy in teaching. In time, the teachers came to realize that mental gifts and social inheritance should be placed above "physical or racial semblances," and the social workers found new ways of working out each case, the author maintains.

The Claremont project demonstrated the value of bringing the three fields together to improve education for the children of minority groups, the author also maintains, and she stresses the importance of using cultural patterns to attain the ends of education. Folkways "may yield to our mechanized age

and universal literacy . . . but principles of cultural existence will persist," she concludes.

PSYCHOLOGY IN COMMUNITY SETTINGS: clinical, educational, vocational, social aspects. Seymour B. Sarason, Murray Levine, I. Ira Goldenberg, Dennis L. Cherlin, and Edward M. Bennett. John Wiley & Sons, New York, 1966. 714 pp. \$12.95.

Written by staff members of the Psycho-Educational Clinic at Yale University, this book describes the activities of the clinic in four New Haven (Conn.) settings—the elementary school system, the local community action program, a mental retardation center, and the clinic itself. It also explores the many problems faced by the schools in trying to help underprivileged children, gives illustrations of work in the school and the community, and describes the methods used in the clinic in day-by-day activities.

The authors' concluding point is that service to the community now requires a

new type of worker—one trained to see cultural anthropology, sociology, psychology, and psychiatry as one field of knowledge, theory, and method. The problem is "how to introduce change into ongoing social systems. The solution will . . . depend on how well we understand these social systems in their terms."

THE CAMP PHYSICIAN'S MANUAL. David Goldring, M.D. Charles C Thomas, Springfield, Ill. 1967. 168 pp. \$8.50.

Written for the physician at a children's camp, this book discusses the "total range of health responsibility in camping": camp standards for sanitation, safety, and the health of workers and the medical and surgical problems a camp doctor is likely to meet, including injuries, animal and insect bites, food poisoning, eye problems, infections, and common diseases. Alex H. Kaplan, M.D., of the Washington University School of Medicine, with which the author is associated, contributes a chapter on the psychological problems the camp

doctor may meet, such as homesickness, bedwetting, anxiety, phobias, and anti-social behavior.

COMMUNICATION TRAINING IN CHILDHOOD BRAIN DAMAGE. Compiled and edited by Merlin J. Mechem, Martin J. Berko, Frances Giden Berko, and Martin F. Palmer. Charles C Thomas, Springfield, Ill. 1966. 392 pp. \$11.75.

The contributors to this volume survey recent advances in and current theories about training children whose abilities to communicate with others through speech, listening, reading, and writing are affected by brain damage. In eight chapters, they discuss such subjects as the disorders of speech and hearing, the role of the speech therapist, the psychological and linguistic meaning of brain damage in children, and special education for the child with brain damage. Their discussion centers on the problems met by those working with such children in psychological testing, speech and hearing therapy, and the classroom.

films on child life

Charges for rental or purchase may be obtained from distributors.

TITLE I—OFF AND RUNNING. 27 minutes (35 mm. filmstrip with magnetic tape sound track, and printed script); color; purchase or loan.

With Johnny Clark, a 12-year-old poverty-stricken boy, as its main character, this filmstrip shows how children who are educationally deprived because of poverty are being helped to learn through special educational programs provided under title I of the Elementary and Secondary Education Act of 1965.

Audience: School boards, teachers, parent-teacher associations, civic groups, and other community organizations; and persons interested in the education of disadvantaged children.

Produced by: Bureau of Elementary and Secondary Education, Office of Edu-

cation, Department of Health, Education, and Welfare.

Distributed by: For purchase, Coe-Peacock, Inc., 8400 Wisconsin Avenue NW., Washington, D.C. 20014; also available on loan from most State libraries.

FOR BETTER, FOR WORSE. 28 minutes; sound; black and white; purchase.

This film presents a study of the relationships of a teenage boy and a girl following their marriage by documenting one evening in their lives and dramatizing some of the problems they were encountering.

Audience: Adolescents from 14 to 17 in discussion groups concerned with family planning, boy-girl relationships,

and sex education; adults in discussion groups concerned with the relationships of parents with their children.

Produced by: TRAFICO-Television, Radio and Film Commission, the Methodist Church.

Distributed by: TRAFICO-Television, Radio and Film Commission, 1525 McGavock Street, Nashville, Tenn. 37203.

PLANNED FAMILIES. 20 minutes; sound; color; purchase.

This animated film, available with sound track in several languages, explains how a baby is conceived and develops, and describes in six detailed segments all the medically approved methods of birth control.

Audience: Patients of maternity and family planning clinics; parent education groups; training classes in family planning for persons in the fields of nursing, medicine, and social work.

Produced by: Allend'or Productions.

Distributed by: Allend'or Productions, 3446 Cahuenga Boulevard West, Hollywood, Calif. 90028.

HERE and THERE



Against discrimination

A children's institution in Denver, Colo., formerly restricted under the provisions of a 19th century will to the care of the poor white "orphan" boys between the ages of 6 and 10 of "reputable" parentage, can now provide care for Negro boys and others who need its services because of a recent court ruling modifying the will's restrictive provisions. The ruling, made by the probate court of Denver early in January in effect eliminated the age, race, poverty, and parental status restrictions in the provisions of a will—made by George C. Clayton in 1892—under which a commission of city officials has been administering the "orphanage," known as Clayton College.

Pointing out that as a "public charitable institution" Clayton College has been enjoying tax benefits not accorded private institutions and that this as well as the involvement of city officials in the administration of the supporting trust had established its nature as a public institution, the court ruled that the provision requiring racial discrimination was in violation of the law of the land. The court also pointed out that if the institution's tax exemption were withdrawn, the trust fund would be so depleted that it could no longer serve the intention of the testator.

Applying the *cy pres* doctrine, which allows a person's testamentary intention to be carried out as nearly as possible when a will's provisions cannot be followed literally, the court interpreted other restricting provisions of the Clayton will as making it impossible for the Clayton Trust Commission to serve the needs of the community and hence to carry out the testator's intention. The court recommended that the word "orphan" be construed to mean the kinds of children most in need of care and that

the age limit for admission to Clayton be raised to 18.

Witnesses—representatives of the Clayton Trust Commission, the Denver Welfare Department, and the Child Welfare League of America—had testified that children who need group care today are likely to be older children who need such care on the basis of personal or family situations other than poverty or loss of a parent by death.

The trustees of Clayton College had not acted to expand the institution for some time because the enrollment had dropped to less than half the capacity and, as the commission's witness testified, was likely to drop even more if the conditions of the will were not changed.

The petition to break the will was brought by the city.

Negro children who attend racially segregated schools do not achieve as well as Negro children in integrated schools, their aspirations are narrower, and they lack confidence in their ability to control the future, the U.S. Commission on Civil Rights maintains in its recent report to President Johnson on racial isolation in the public schools, prepared at the President's request. The community often treats schools in which Negro children are in the majority as inferior, and this view is often shared by administrators, teachers, students, and parents, to the detriment of the Negro child's ability to achieve, the Commission points out.

Based on data from school systems, research sponsored by the Commission, and testimony given in public hearings by school officials, teachers, parents, and civil leaders, the report also includes these observations, among others:

- School segregation is widespread throughout the Nation and is increasing as white people move to the suburbs

and leave the city proper to the Negro. Open housing would help break up segregated neighborhoods, but a generation might pass before it could change the composition of the schools.

- Negro children need special attention in school such as small classes and excellent teachers, but, most of all, they need opportunities to associate with advantaged children. Most projects to help overcome the disadvantages of poor environment in large cities have not had lasting effects. Segregated schools in the city cannot be eliminated without the help of suburban schools—both must join together to set up large centers and educational parks where children from many environments will have wide opportunities to learn together.

- The U.S. Congress could help end the isolation of the Negro child by setting up standards for desegregation and programs of financial aid to States to help them meet the standards.

The report, "Racial Isolation in the Public Schools," has been published in two volumes (the second volume consists of appendices). (Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, \$1 each.)

Population projections

By 1985 the population of the United States may be one-third again as large as in 1966, according to recent estimates of the Bureau of the Census. Projections in series B (one of four series recently issued by the Bureau, based on different assumptions) show a population of 196.8 million for July 1, 1966; 207.3 million for 1970; 223.8 million for 1975; and 264.6 million for 1985. Behind series B projections is an assumption regarding fertility: that the average number of children per 1,000 women at the end of their childbearing years (15-44) will be about 3,100, or at about the same level as in the years 1964 and 1965. (Provisional figures for 1966 suggest this estimate may be high.)

Coupled with this assumption is the further assumption of a gradually increasing birth rate through 1984 estimated to produce approximately 4.64 million live births a year by 1970; 5.43 million, by 1975; 6.04 million, by 1980; and 6.31 million, by 1985. On this basis the estimated newborn population of 3.89 million in 1966 will increase 19.2 percent by 1970; 39.5 percent by

1975; 55.2 percent by 1980; and 62.1 percent by 1985.

The number of women in the child-bearing ages is expected to reach 56.5 million by 1985, increasing from an estimated 39.5 million in 1966.

The number of children under 15 years of age is expected to increase from an estimated 60.1 million in 1966 to a projected 83.1 million in 1985, or about 38.3 percent. The number of people in the age range from 25 through 64 will increase somewhat less rapidly. Thus the ratio of children to adults will increase from 695 children under 15 per 1,000 adults ages 25 through 64 in 1966 to 722 per 1,000 in 1985, about a 4-percent increase in child-rearing responsibility.

The estimates are reported in "Current Population Reports," Series P-25, No. 359, issued by the Bureau of the Census on February 20, 1967. While the figures quoted here are confined to series B alone, the report includes estimates and projections for four series (A, B, C, and D), which differ from one another in respect to assumptions on fertility after July 1, 1966. The assumptions regarding mortality and net immigration are the same in all series. These recent projections differ very little from those published earlier by the Bureau of the Census on March 10, 1966, in Series P-25, No. 329, in which the changes are confined largely to slight rises in the entire population and in births.

A later report in this P-25 series will give complete results and a detailed description of the methodology and assumptions.

Coordinated services

In September of this year, the School of Social Service Administration of the University of Chicago will open a Social Services Center—a multipurpose unit for the Woodlawn community, a low-income area adjoining the university campus. The center is designed to provide the neighborhood with a cooperative network of tax-supported and voluntary agencies working together, under the school's general supervision, to provide more effective services, to develop new programs, and to improve the quality of the agencies' staff through training. Three public agencies providing programs for children and their families will operate in the

center at the outset, and the center's staff will make a major effort to bring community agencies not located in the building into close cooperative program development and coordination.

The plan for the Social Services Center is the sequel to a feasibility study made by the school in 1965-66 with a grant from the Children's Bureau. Funds for the building are being sought through the neighborhood facilities program of the U.S. Department of Housing and Urban Development, which has reserved \$1,291,000, pending the development of final plans, for a grant requested for the university by the city of Chicago. The building is expected to be ready for occupancy late in 1968.

The opening of the center in temporary quarters this fall before the new building is completed has been planned to provide an opportunity for testing the center's design of operation and new patterns for fieldwork placement of social work students. The initial programs to be included are the maternal and child health services of the Chicago Board of Health, the program of aid to families with dependent children of the Cook County Department of Public Aid, and child welfare, legal services, specialized education, and community organization programs operated by voluntary agencies.

Major organizational elements include provision by the School of Social Service Administration of a program director for each major area of service to provide liaison and coordination, the formation of a council of center-related agencies and organizations, and the establishment of an advisory committee of Woodlawn residents.

The School of Applied Social Services at Western Reserve University and the George Warren Brown School of Social Work at Washington University are now developing similar plans with grants from the Children's Bureau.

. . .

The Secretary of Health, Education, and Welfare has established a departmental committee on children and youth to coordinate all activities and programs within the Department designed to develop the potentials of young people. Under Secretary Wilbur J. Cohen heads the committee; its other members are Philip R. Lee, M.D., Paul A. Miller, and Lisle C. Carter, Jr., assistant secretaries, respectively, for

health, education, and individual and family services. In addition to coordinating present programs, the committee is charged with advising the Secretary on new proposals for new programs to help meet the needs of young people in the 1970's.

Agricultural migrants

Texas was the first State to receive a Federal grant under the 1966 amendments to the Elementary and Secondary Education Act of 1965 for a program to improve the education of the children of migrant farm workers. All States except Alaska, Hawaii, and Rhode Island and the District of Columbia—which have no migrant farm workers—are eligible for grants to improve the education of migrant children, and nearly all States have plans either approved by or pending in the U.S. Office of Education.

In Texas, the home base for the bulk of agricultural migrants in the Midwest and western migrant streams, 40 schools in various parts of the State provide 20,000 children of migrant farm workers with a 9-month program of schooling in 6 months, including intensive work in English, reading, science, hygiene, and other subjects. Before the Office of Education grant was made on December 22, 1966, the program received support from the Office of Economic Opportunity.

Other States with approved plans include California, New York, Indiana, Florida, New Mexico, Washington, Colorado, Louisiana, and New Jersey. California will conduct a model program of supplementary education in three counties: New York will offer summer school programs to migrant children; Indiana will train teachers for Spanish-speaking children; and Florida, Alabama, and Georgia plan to establish a coordinated program for migrant children to be administered by the Florida State Department of Education and to involve the development of regional instructional materials, curriculum, and teaching methods, and a method of transferring scholastic and health records.

. . .

A study of child-rearing practices among Negro agricultural migrants in central Pennsylvania has revealed many areas of strength, according to the inves-

tigator, Mable B. Anderson, who carried out the study while working on the staff of a day-care center for migrant children during the summer of 1962. In the study, 64 mothers of 84 children in three Pennsylvania counties were asked about their child-care arrangements and child-rearing practices.

Over half the mothers with children aged 3 to 6 used one of the two day-care centers provided for migrant children between 3 and 11 in these counties. Many mothers, however, took their children under 3, including infants, to the fields with them because they had not been able to make other arrangements and did not wish to leave the children uncared for; and many reported being unhappy about this type of arrangement. All the children over 11 worked in the fields, as did some children as young as 9.

The mothers were not severe in their discipline of the children, not even in toilet training, the investigator found. On the other hand, they were not lenient where sex was concerned; they disciplined the children for sexual curiosity and genital play because they were concerned about the children's health and safety.

The mothers encouraged the children to care for themselves—to bathe and to dress, for instance. In this respect, the children exceeded their mothers' hopes, many mothers reported.

About two-thirds of the mothers said they had received ideas about child care from "medical sources," and many had printed material at hand.

On the whole, the mothers had from 4 to 6 years more education than the mothers studied by other investigators in a survey of east coast migrant workers made at about the same time at another site, and they respected education. While all expressed the wish that their children would get more than an elementary school education, about one-fourth gave some indications that this was either economically or intellectually attainable.

Nearly all the mothers in the Pennsylvania study had received prenatal care; for about half of them the care had begun in the first 3 months of pregnancy—less than 10 percent of the mothers in the other study had received prenatal care as early as this. This difference the study director attributed to the fact that the Pennsylvania migrants had health services available to

them at their home base in Palm Beach, Fla.

The differences in the findings among the two groups of east coast migrants Dr. Anderson regards as evidence that generalizations cannot be made on broad groups of people from local studies.

Child care

A cleft palate or lip in a child is not necessarily a deterrent to adoption, the Montana State Board of Health and the State Department of Public Welfare have found. A recent review by Venus Treitsven, coordinator of the cleft palate program, and Wilma Smyth, medical social consultant, of the State Board of Health's division of child health services, of the 337 children with clefts born in the State between 1955 and 1965 showed that 8 of the 11 needing families other than their own have been placed in adoptive homes. Except for one who died from a sudden infection, the children are getting along well. The adopted children include both Indian and Caucasian children, several of whom have more than one handicap—one, for example, is mildly retarded; another has deformities of hands, feet, and neck.

The adoptions followed close work between the social workers of the State Department of Public Welfare and the Lutheran Social Services, the agencies responsible for the placements; the specialists of the cleft palate teams of the State Board of Health; and the local public health nurses.

One of the three children remaining in foster care—where they were placed because of parental neglect—has been relinquished by his parents for adoption also, although adoptive placement has not yet been made.

. . .

For a child-caring agency to act as a "parental force," accepting responsibility for all aspects of a child's life can effect greater stability in emotionally disturbed children in foster care, according to a study conducted by the Iowa Children's Home Society, in Des Moines, with a demonstration grant from the Children's Bureau. Though the agency, a voluntary child-care agency, set out to determine whether the "split case" method—having one caseworker act as a therapist and another as a "parental force"—or the

"single case" method—having one caseworker perform both functions—was more effective in helping the emotionally disturbed children selected for the project, the agency found that all the children improved. The study included 24 children, aged 7 to 16, from similar backgrounds who were in foster families, group homes, or residential treatment centers and were expected to need care away from their own parents for at least 2 years. They were assigned at random to the two methods.

As the "parental force," the agency provided the children with an "underpinning of authority" that supported the needs of the children and was a constant factor in their lives, according to the project's director, Edith Zober. She reports that the children seemed to know that the agency was acting as a parent in assuming ultimate responsibility for all aspects of their lives—school, foster home adjustment, peer adjustment, and, in some instances, beginning adjustment to work.

As a result of the project, the agency has defined its primary method of working with emotionally disturbed children in foster care as reestablishing a functional parent for the child.

Education

By the first of March this year, 64 projects to improve the education of the nearly 50,000 children attending the schools operated by the Bureau of Indian Affairs, U.S. Department of the Interior, had been approved for grants from the Office of Education, U.S. Department of Health, Education, and Welfare, under the 1966 amendments to the Elementary and Secondary Education Act of 1965.

The grants have been made for improvements of classwork, cultural enrichment, and the meeting of special needs in day schools and boarding schools operated by the Department of the Interior. They are, for example, providing for additional teachers and teachers' aides to facilitate language instruction, summer programs, and pre-school, remedial, and enrichment activities and to reduce the size of classes; guidance counselors and school social workers; food and transportation services; the expansion of physical education and recreation programs; special education of the handicapped; and special services for pregnant girls.

IN THE JOURNALS

Treating the whole family

Pointing to the importance of having a treatment goal for each member of the family, Otto Pollack, in the March 1967 issue of *Child Welfare*, suggests that team counseling of the family as a group be used not only for intact families with problems of intrafamily relationships but also for broken families, adoptive families, and foster families. ("Disturbed Families and Conjoint Family Counseling.")

The author, who is professor of sociology at the Wharton School, University of Pennsylvania, also suggests that the content of family therapy with the different types of families will vary. For example, he says, with broken families it may include coping with problems of guilt, anger, and fatigue not likely to appear in intact families and with pressures on the remaining members to take over the role of the absent member; with foster families, problems connected with the demand for emotional commitment without the security of permanence, the experience of sibling rivalry and intimacy without the correctives of a blood relationship or incest taboo, and the threat of parental autonomy represented by the caseworker or the child's own parents; with adoptive families, some of the same problems connected with the absence of blood tie controls as in foster families, or concern over an equitable distribution of the parents' affection between their natural and adopted children. The author further suggests that two therapists—a man and a woman—working with the family as a team can provide the members of a foster or adoptive family with a model for impulse control.

Tracing the development of family group therapy in the past decade, from the recognition of therapists more than 20 years ago that improvement in one member of a family following individual therapy of sometimes accompanied by deterioration of another, the author maintains that conjoint family therapy,

whether provided by a team or an individual therapist, can restore communication between the members of a disturbed family who have built "walls of psychological privacy" around themselves and can thus begin the healing process.

Family law

A new journal, *Family Law Quarterly*, published by the American Bar Association, Section of Family Law, which made its initial appearance in March of this year, will, according to the preface, concern itself "not merely with those questions which are now clearly in the domain of family law (e.g., alimony, adoption, divorce)" but also with subjects "with which lawyers handling domestic relations should be familiar" such as marriage counseling, the rights of children who do not live with both parents, and proposals concerning a change in abortion laws.

Among the articles in the first issue is one commenting on three 1966 custody decisions in Iowa in each of which a parent was denied custody of a child he or she had once voluntarily placed with the child's grandparents. ("Child Custody: Iowa Corn and the Avant Garde," by David N. Levine.) The author points out that in each case (*Painter v. Bannister*, 140 N.W. 2d 151; *Alingh v. Alingh*, 144 N.W. 2d 134; and *Halstead v. Halstead*, 144 N.W. 2d 861) the Supreme Court of Iowa placed the doctrine of "the best interest of the child" above the "natural right" of the parent to the child. Finding in these decisions a definite advance over the "unfortunate vestige of the feudal era," rigid adherence to the natural right theory, the author, however, warns against just as rigid adherence to a *parent by association* doctrine without giving serious consideration to psychological and psychiatric testimony. Pointing out the difficulties of arriving at the "best interests of the child" in a case like the highly publicized *Painter*

case, in which the suing father, "a wholly fit person" had after his wife's sudden death relinquished custody of his son only temporarily to the maternal grandparents for whom the boy proceeded to develop a strong attachment, he concludes that the final judgment must be the court's, but that judgment must follow intelligent appraisal of the case and not be "rigidly predetermined."

Family planning

Because of the lack of clarity as to the nurse's role in family planning today, nursing education programs need to integrate family planning concepts and skills into their basic nursing curriculum, says Sister Mary Helen, coordinator of maternal-child nursing, University of San Francisco School of Nursing, in the March 1967 issue of *Nursing Outlook*. ("Family Planning Within the Curriculum.") This approach, she says, will enable nurses to function effectively in any family planning program. However, she adds, planning for such a program must take into account the institution's philosophy and the ideas, previous experience, and cultural background of the teachers and the students who are to participate.

The author describes the principles followed in incorporating family planning content into the University of San Francisco's baccalaureate nursing program, which is developed on three "core threads"—family-community health, problem-solving, and leadership. She cites the following goals for the student:

- The formulation of a realistic, satisfying personal attitude about sexuality and her role as a woman.
- The ability to apply problem-solving methods to patient situations as well as to her own.
- The development of skill in interviewing.
- An understanding of the need for family limitation as a social as well as an individual family problem.
- Recognition of the goal of family planning as strengthening the family.
- Recognition and respect for the rights of individual couples to choose their family size.
- Knowledge of the various methods of birth control and a demonstrated ability to explain their use.
- Understanding the nature of the

nurse's role in family planning programs.

• Awareness of her own limitations, and ability to seek counsel when indicated and to refer patients to appropriate resources.

Living with leukemia

The old theory that the less children with leukemia discuss their problems and progress, the less upset they will be is no longer accepted at the leukemia service of the National Cancer Institute, write Joel Vernick, former social worker in the institute's children's program, and Janet L. Lunceford, head nurse of the cancer nursing unit, in the March 1967 issue of the *American Journal of Nursing*. ("Milieu Design for Adolescents with Leukemia.")

The article describes the institute's program of providing adolescent leukemia patients with opportunities to discuss their fears, anxieties, and problems in unscheduled individual or group interviews with the nursing unit's social worker and nursing staff. This program, which includes all children ages 9 through 21 admitted to the service, has resulted in lessened anxiety and in more healthy emotional functioning among them, the authors report.

The young people are given frank answers to their questions but are told there is always hope and that every-

thing possible is being done to get them well enough to return home. Questions that cannot be answered by the social worker or nursing staff are referred to the chief pediatrician.

The authors also point out that the children are encouraged to function as normally as possible—to attend school in the building when they can, keep their rooms neat, obey the hospital rules, and participate in and attend recreational activities such as gym exercises, arts and crafts, weekly movies, band concerts, picnics, sightseeing tours, and trips to the drugstore. Bedside programs of occupational therapy are offered when necessary.

High risks of schizophrenia

Children of two schizophrenic parents have about a 35-percent "risk rate" of developing schizophrenia, as compared with the 1-percent risk rate among children in the general population and a 7- to 15-percent risk rate among children with one schizophrenic parent only, reports David Rosenthal, chief of the laboratory of psychology at the National Institute of Mental Health, in analyzing five studies of children of schizophrenic parents in the December 1966 issue of the quarterly *Journal of Psychiatric Research*. ("The Offspring of Schizophrenic Couples.") The studies in-

cluded 99 children of 65 schizophrenic couples.

The author presents evidence both for and against the implication of a dominant gene in the development of the disease and concludes that both genetic and environmental factors are involved. Reflecting on "what the home life of a child with two schizophrenic parents must be like," he points to the difficulty of distinguishing between the extent of the influence of "domestic chaos" and of "genetic chaos" on the rate of schizophrenia among such children.

According to the author, the findings also indicate that perinatal mortality is higher among infants born to schizophrenic parents than in the general population, that it is higher among children whose mothers only are schizophrenic than among children whose fathers only are schizophrenic, but that it is no higher among the children with two schizophrenic parents than among children whose mothers only are schizophrenic. Here again, he suggests, there is difficulty in determining how much of the differences in rate can be laid to the effects of the disease-carrying gene on the fetus and how much to noxious factors derived from the mother's schizophrenic state, such as the ingestion of drugs, coma or convulsion inducing treatment, inadequate diet and exercise, and prolonged anxiety.

guides and reports

FAMILY PLANNING PROGRAMS IN THE WAR AGAINST POVERTY: a guide for community action programs. Planned Parenthood-World Population, 515 Madison Avenue, New York, N.Y. 10022. 1966. \$3.

A kit of guide materials for developing a local family planning program.

TRAINING SERIES FOR SOCIAL AGENCIES—Vols. I through VIII: Implications of Social Change; Changing Interpretations of Behavior; Social Agencies and Social Change; Poverty in the United States; Reaching the Disadvantaged

Child; Dropouts and Training; Delinquency and Treatment; and Planned Change. Edited by Robert Schasre and Jo Wallach. Youth Studies Center, University of Southern California, Los Angeles, Calif. 90007. May 1966. \$1.50 each.

A reading series of published and unpublished material focused on the poor and culturally disadvantaged for use in education and training in the field of social service.

REARING CHILDREN OF GOOD WILL: a program guide. James M. Eagan. National Conference of

Christians and Jews. 43 West 57th Street, New York, N.Y. 10019. 1966. 38 pp. 35 cents.

Offers suggestions for helping children in the home, school, church, and community grow up without prejudice toward others of different race, religion, or national origin.

GUIDE FOR ESTABLISHING AND OPERATING DAY CARE CENTERS FOR YOUNG CHILDREN. Dorothy Beers Boguslawski. Child Welfare League of America, Inc., 44 East 23rd Street, New York, N.Y. 10010. 1966. 100 pp. \$2.50.

Describes the purposes and program of a day-care center for children, the roles of various types of staff members, housing and equipment needed, the sources of financial support, and the importance of a State licensing law.

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Family Life and Sex Education

A Maternity and Infant Care Project

Neighborhood Youth Corps Progress

Volunteers in Work With Children



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Young love—or at least a mutually interested boy and girl. How their relationship grows and how wholesomely they respond to each other may depend on what they have learned about sex and its place in a mature life from their parents, teachers, or religious counselors. (See pp. 130 and 136 for discussions of sex education.)

Children

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Today many parents who themselves were reared by mothers and fathers afraid to educate their children in sexual matters are now afraid *not* to educate their own children regarding sex. Social pressures on young people different from the kind they experienced when young, prevalent attitudes toward sex that reflect a changing value system in society as a whole, and behavior among many young people that they do not understand have left today's parents perplexed and anxious. As a result they are eagerly seeking help for themselves and for their children, whom they want to achieve "normal sexual maturity."

Community agencies, youth organizations, churches, and schools are all scurrying to initiate programs of sex education—sometimes called family life education, boy-girl relationships, or interpersonal development. Inservice training programs, workshops, and institutes are being organized for nurses, social workers, clergymen, teachers, counselors, health educators, community youth leaders, and parents. After a long period of being treated with silence or half-truths, blushes and snickers, the subject of sex can openly be talked about in "respectable" society. Young people's attitudes and behavior toward the opposite sex—and the consequences—are the subject of serious concern not just to adolescents and their parents but also to persons in the teaching and helping professions.

Nevertheless, the goals of sex education are not altogether clear. Nor is it clear just whose responsibility it is to give sex information to children and adolescents and to try to shape the attitudes that determine their moral values and sexual behavior. Dealing with the sexual problems of young people is especially difficult for adults brought up in a society confused about sex, one that has been filled with sexual stimuli and at the same time with harsh taboos against sexual expression. Social scientists are not surprised that the combination of stimulation and repression has resulted in a demand for a "better way" of dealing with sex.

In response to the demand, persons who work professionally with children, adolescents, and parents are seeking *the* way (if there is *one*) or *a* way (if there are *many*) to help children grow toward "sexual maturity." This goal in itself is difficult to define, and to chart a course leading to its achievement is even more challenging.

Sexual behavior among men and women and sexuality as it is manifested in masculinity and femininity vary from culture to culture. Anthropologists tell

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HELPING

HOW?

WHEN?

BY WHOM?

us that there is no sexual practice that has been universally sanctioned or prohibited; even incest, the sexual behavior that comes nearest to being universally tabooed, has been approved in some societies in some periods of history.

In any culture, what is "normal" depends upon the practices of the majority. Many behavior patterns that are quite objectionable in our society are sanctioned in others; for example, homosexual practices, sexual relationships between children, premarital sexual promiscuity, and wife swapping and borrowing are approved forms of behavior in some societies. It is not possible to speak of what is or is not "normal" unless we specify the society to which we refer.

Normality? maturity?

Even in this country alone the wide range of sexual behavior and values existing today make "the norm" impossible to define. At one extreme are those people who advocate complete sexual freedom amounting to anarchy; at the other extreme are those who condone the use of sex only for reproduction. Between these extremes lies immense variation in attitude and practice. For example, chastity before marriage is held to be a supreme value; it is considered "a good thing"; it is thought not to be very important; it is valued not at all; it is considered a poor thing. Masturbation is valued as a means of releasing sexual tension; it is considered an acceptable adolescent pastime; it is thought to be a shameful practice or a sin. Marital practices vary: there is no consensus on

how frequently coitus should take place, nor on the appropriate position, nor on the amount or kind of foreplay that is acceptable. Most social scientists agree that it would be difficult if not impossible to define the norm of sexual behavior in contemporary American society. Even if such a norm could be defined, the definition would be meaningless, for sexual expression is a highly individual matter, an integral part of the total personality.

Sexual maturity rather than sexual normality may be a better goal for sex education. Even so, we must make assumptions that cannot be validated about the nature of man and the patterns of his maturing. By careful measurement and observation we have learned a great deal about the physical growth and development of boys and girls; we know about many of the factors that contribute to or detract from soundness and roundness of body; we have been able to trace general developmental patterns from the prenatal period to maturity and then to decadence. Intellectual growth has been more difficult to discover and predict in a sequential pattern, but in general we know a good deal about such aspects of growth as language development, concept development, learning, and creativity.

What we know of emotional growth is still largely theory or educated guesses; and social patterns that propel a child on to becoming a socially mature adult are known to vary from generation to generation. Even so, through keen observation, crude but persistent evaluation, and creative speculation, we can draw at least some tentative conclusions about the

emotional and social development of the human being.

When we realize that sexual growth includes factors that are physical, intellectual, emotional, and social, it becomes clear that with the incompleteness of our knowledge it is impossible to trace a sequential pattern of sexual development and to predict maturity with any degree of precision. This is a task to be explored by scientific research. We cannot wait for the results, however, to define our social goals in broad terms and to plan the practical steps toward their achievement.

The goals

As with other social goals, the consideration of educational goals requires two foci: the individual and the group in which he lives. Managing these two compatibly is a constant challenge for a democratic society. It is a greater challenge today than ever before, for in our rapidly changing society young people are demanding greater freedom in individual behavior than in any previous generation.

Our society has not yet provided an adequate way of caring for children born out of wedlock; it is therefore desirable today to discourage out-of-wedlock births. This is one social goal on which we can secure a great deal of agreement. Another is the elimination of venereal disease. So far, we have found no medically satisfactory way of preventing venereal infection. Both of these goals are served when premarital, promiscuous intercourse is avoided. Thus, at this point in our social development, it is reasonable to want to restrict premarital coitus.

However, with the increased effectiveness and availability of contraceptives and with the possible future development of immunizations against venereal diseases, the social consequences of promiscuous premarital sexual relationships will change. Insofar as morality is based on social consequences, when the consequences change the moral values change. What is immoral in today's society may be moral in tomorrow's. And what is right for today's generation of young people may be wrong for a generation to come.

One way to avoid getting hopelessly involved in dilemmas is to go beyond what is presently called "sexual morality" to a broader concept of morality, one based on the use of self and one's personal freedom for the benefit of others.

Broader definitions of goals are appropriate, too, in considering the individual's personal growth and satisfaction. Here the goal is not only a sexually ful-

filled person but also one who accepts and values his total self—a person who understands himself, his behavior, and his value system and who has the integrity to defend his principles. The ultimate goal is a person who can communicate with others without fear, who can reveal himself, and who can listen to and be concerned about the welfare of others.

Sexuality can never be separated from personality, nor can sexual morality be separated from social morality. For this reason the term "sex education" tends to be misleading. By emphasizing sex it pulls the subject out of a total context. Unfortunately, our culture has for a long time treated a sexual relationship as a special and separate part of personal and social relationships rather than a normal, natural use of self in relating meaningfully to a person of the opposite sex.

Now, because of the need to provide information, to correct misconceptions, and to break the spell of silence, it will be hard for any program of sex education to avoid further isolating and emphasizing the sexual components of personality and interpersonal relationships. Nevertheless, the real goal of any program must be to help in the total development of young people so that they will become the kind of secure persons described above. If we can achieve this goal, we will not have to worry about sexual behavior.

How and when?

The questions of *how* and *when* are better dealt with together, because, except for always giving children frank, honest answers and explanations, the most important point about sex education is to provide the information in a normal context. Sexual matters need to be dealt with as the natural part of a total picture, whatever that picture may be. When children are curious about their own bodies—hands, feet, elbows, and "tummies"—they are also interested in their genitals and need to know proper terms for them. When children are interested in what happens to food in the human body and in why and how we breathe, they are also interested in the excretory functions and need proper explanations about them.

Most of a child's early questions about sex are occasioned by exposure to a situation that is new to him. He sees an adult body and notes that it is different from his own; he wants to know more about it. He sees a child of the other sex and notes that the genitals are different; he wants an explanation. He sees a pregnant woman and wants to know why her

stomach is swollen, and he also may want to know how this came about. The child usually brings these questions to his mother because they occur to him before he reaches school age.

The way in which these early questions are answered largely determines what other questions the child will ask, how he will feel about asking them, and how he will feel about the answers. A parent reveals his own feelings about sex through common, everyday events in many ways. His attitudes will be regarded by his child as those of all adults, so that what questions the child asks or does not ask the teacher at school depend a great deal on the kind of reception they would get if asked at home.

In the school the teacher has continuous opportunities to answer questions bearing on sex that come up in the ordinary events of the day and in the content of every subject. From kindergarten through 12th grade, the child can be encouraged to develop a normal progression of interest in and an increasing body of information about family relationships and sex differences and functions and, in doing so, to form values and make decisions about behavior. In the elementary grades imparting information about animal and human reproduction is becoming a routine part of instruction. However, helping children understand their own developing masculinity or femininity is more difficult for the teacher because it involves a personal concept that can be discussed more naturally in the home than in the schoolroom; nonetheless, much thought about the meaning to oneself of one's sex can be stimulated at school through units in self-understanding and personality growth.

Many persons believe that the school has a better opportunity than the home to present the child with *information* regarding sex. This is partly true, at least, because teachers tend to be more knowledgeable than many parents about physiology, anatomy, health, psychology, and social problems. It is true, also, because as the child progresses through the grades the teaching becomes concentrated into subject areas, many of which relate specifically to sex and reproduction, to social-sexual-psychological development, and to social problems and health. Thus information about sex is not only a normal part of the subject matter in junior and senior high schools but is also an integral part that has to be conspicuously avoided if it is *not* to be included.

Every school subject, even one not directly concerned with sex information, has its contribution to make in helping children and young people understand interpersonal relationships, familial roles, and

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the relation of one's sex to these. Literature, music, art, history, and the social sciences especially offer such opportunities.

The home and the school are not alone in having opportunities to help the child develop a mature understanding of sex. Groups such as the Boy Scouts, Boys' Clubs, Girl Scouts, Girls Clubs, Camp Fire Girls, Young Men's Christian Associations, Young Women's Christian Association, and 4-H Clubs are dedicated to helping young people develop healthy bodies and well-rounded personalities. Most of these organizations work informally with adolescents or preadolescents in small groups over a span of a few years. They offer the young person an excellent opportunity to develop a self-confident personality, including an acceptance of his sexual identity: they also offer him practice in forming intimate, meaningful relationships with others, both of his own and the opposite sex. The sexual aspects of interpersonal relationships become especially important during adolescence when cultural expectation pushes young people toward dating, and their own heightened sex drive urges them toward exploration.

It is not possible to give information without at the same time conveying attitudes, and the attitudes of adults determine the values of the young, which in turn determine their behavior. The values that young people hold are those that have been demonstrated by the persons they respect.

The churches, of course, are specifically concerned with the values in our society and more than any other institution except the home are expected to take responsibility for the development of attitudes in keeping with their religious and moral precepts. However, such value positions are only meaningful to young people if they are clearly enunciated and are demonstrated as useful in today's society.

Perhaps the most consistent informers about adult attitudes and builders of young people's ideals today are not the traditional institutions that purposefully outline and pursue programs or policies of

education but rather the mass media of communication: the television that the child watches from the time he is too small to respond to much more than the movement and the sound to the time he is able to sit for several hours absorbed in its entertainment programs and its advertisements that use sexual appeal to sell products; the magazine illustrations, the comic strips, the paperback book covers, the films that make the sparsely clad body a common sight and the seductive female or male an appealing personality. The child exists so constantly in the midst of these stimuli that as his own understanding grows they become increasingly meaningful to him. This is sex education in the context of commercialism, of entertainment, and the message it conveys, while often indirect, is powerful.

All these agencies of society—the home, the school, the community agency, the church, the mass media—bring their messages to the child in one way or another almost from infancy. Some of the messages are direct, some are subtle; they are seen, heard, felt. Some of them are quiet, some loud; some are conspicuous chiefly because of their absence. Some are true; some, half-true; some, false. Altogether they are very inconsistent. As a result our children come to adolescence confused, curious, and often determined to find out on their own.

If the adults who touch the lives of children could determine what their own values are, if they could know beyond question why they hold these values, and if they could demonstrate them in their daily living, children would get their message. If adults themselves could put sexual matters into the normal context of living, young people would be better able to do the same. The ultimate problem for adults is not so much how to educate children and adolescents as how to work out their own problems and how to convey their attitudes to the young people whose lives they influence. That adults who are significant for them do not readily have all the solutions will not distress the children nearly so much as people seem to think. Children will not feel confused about seeking many of their own answers to the problems of interpersonal, intersexual relations if they realize that adults too are honestly seeking solutions.

By whom?

Who it is that is responsible for sex education becomes clearer when we recognize that sex education is a segment of an individual's total preparation for living in a complex world of interrelatedness,

and that information and attitudes specifically regarding sex are normal parts of knowledge and of a social value structure. Every adult who deals with children or adolescents in any way is likely at some time or another, in some way, to influence significantly the attitudes that help determine how a child will use himself—sexually as well as in other ways—in relation to other people.

Because most adults today have not had the advantage of growing up in a society in which the kind of sex education advocated here was available, many adults find it difficult to deal with their own attitudes and to communicate them in an open way to children and adolescents. Some adults, however, are able to do this better than others, and those who *can*, must! The opportunity that adults have to do so will largely be determined by their role in relation to the young. The parent has the longest and most intense relationship with the child and so the greatest opportunity; the teacher, the school nurse, the school counselor, and the principal each has significant opportunities from time to time, as does the youth leader, the clergyman, and the religious educator. So too, does the advertising man, the sales manager, the editor, the journalist, the filmmaker, the television or radio director.

Where to begin?

In a wilderness that seems so vast, adults who are concerned with helping children and adolescents grow up sexually are likely to feel that it is all but a hopeless task. This, it is not. In addition to setting his own house in order and examining his own values and behavior and being open about them, the person who works professionally with young people can take a number of steps toward furthering a program of education that will make for mature sexual behavior in our society:

1. He can help other professional workers define their values and learn how to convey them to others. One of the most helpful tools for this kind of learning is the sensitivity group, sometimes called the T-group. Composed usually of about 10 persons with a professionally trained leader, the group is designed to encourage its members to explore their feelings and to interact in such a way that insight and self-understanding develop.¹

2. He can take part in inservice training sessions, workshops, and institutes that provide the participants not only with information but also with an

opportunity to clarify their own attitudes for themselves. Because acquiring information is usually accomplished much more quickly than acquiring insight into one's own feelings, the emphasis in the most effective groups is on the exploration of the participants' attitudes.

Many universities and colleges are now offering such courses, and many more would set them up if requested.

3. He can focus much of his educational efforts on parents, especially parents of infants and very young children. Because the parental influence is so constant and so intense, what parents believe, what they convey, and what they know are crucial influences in the development of the child's sexual attitudes.

Parents, however, often have uncertainties and fears about their own sexuality that inhibit their ability to help their children—for example, a mother who does not value her femininity will find it hard to help her daughter grow up to accept and value herself as a woman.

Parents also often need some of the skill that persons in the helping professions have in giving direct answers to questions about sex, and often they also need the information itself. Some parents, for example, have misconceptions about the effects of masturbation on the developing child; some do not understand the physiology of menstruation; and some have fears and apprehensions about their own sexual functions, the use of contraceptives, the effects of menopause, or their marital compatibility.

Thus many parents might benefit from the same kind of sensitivity group suggested for professional persons. The opportunity for parents to discuss such problems in a safe, accepting group of other adults could help them clarify their own feelings and thinking and learn how to deal with intimate matters openly and frankly. Such groups might be formed through a neighborhood house, an elementary-school guidance program, a parent-teacher association, a church, or any other local organization. A trained professional leader, however, is a *must*.

4. He can make known to the molders of the mass media his convictions regarding the use—and mis-

use—of sexual stimuli, particularly in advertising and in entertainment. If he finds that young people are being given a false or unclear picture about the meaning of sexual maturity through any form of mass communication, he can protest.

More important than all these steps, however, is the professional person's way of dealing directly with young people. Can he be open and willing to share his time, thoughts, and knowledge with the questing young? Anything less is not enough. The young have the right to honest answers—even when the adult's answer must be that he does not know or is himself confused.

And so—

Helping children grow into sexual maturity is not easy for a generation of adults who have grown up in a society frightened of sex. It can only be done by breaking through the silence and half-truths that have obscured their own knowledge and feeling and by establishing a broader objective than mere "sex education." This means striving for the development of the whole personality, for producing a man or woman able to feel genuine concern for the welfare of others, eager and able to establish intimate relationships with others, desirous of parenthood, and capable of assuming the responsibility of his own freedom.

Professional workers concerned about young people need to clarify their own attitudes and values and to develop ways of communicating them to others. When they do, they can be of special help to parents and to other professional workers—teachers, nurses, school counselors, principals, social workers, youth leaders, clergymen. They can influence the mass media's interpretation of sex and interpersonal relationships. They can help young people with the problems troubling them, always keeping sexual information in the context of the whole person, being honest and frank, and admitting that along with the young people, they, too, are *seeking*.

¹ Bradford, L. P.; Gibb, J. R.; Benne, K. D. (eds.): *T-group theory and laboratory method*. John Wiley & Sons, New York, 1964.

A good motto for any investigator of the subject [the sexual behavior of adolescents] would be this: whoever asks questions must expect to be told lies.

D. W. Winnicott, *child psychiatrist, Paddington Green Children's Hospital, London*, in "The Family and Individual Development," *Basic Books, Inc., New York*, 1965.

starting a

SEX EDUCATION PROGRAM

LESTER A. KIRKENDALL • HELEN M. COX

● Growing public interest in sex education across the Nation has resulted in efforts to “start” sex education programs in many communities. Typically, these efforts are involving physicians, nurses, social workers, religious leaders, and members of civic groups, as well as teachers and school administrators, many of whom are puzzled about where and how to begin a program on a topic often denied formal recognition because of repression and fear. Since our experience has been with sex education programs in the schools, our discussion will center on what we have found to be successful methods of developing sex education for both the community and the school.

The school “starting” a sex education program can “start” in a relative sense only. Sex education, broadly defined, occurs inevitably in both home and school. The student learns something about reproduction in biology class; about family life in social studies; and about love between the sexes in literature classes through poems, plays, and novels. Both at home and at school he sees men and women relating to each other with love or hostility. He notes that sex is treated openly, ignored, or evaded. Though much of his learning is nonverbal and attitudinal, it is learning. For this reason, any school, any community is fully warranted in saying that it is “expanding and improving” rather than “starting” a sex education program. In presenting the idea of formal sex education in the school to the public, school officials would do well to keep this in mind. The public is less afraid of expanding than of innovating and has more con-

fidence in the judgment of school officials who have forged ahead than of those who, because of fear or indifference, have neglected an important aspect of education.

Scope and content

For almost everyone, “sex education” means teaching what is actually the “physiology of the reproductive systems,” an essential aspect but far from all of it. We need a broader idea of sex education than this—such as that offered by the Sex Information and Education Council of the U.S. (SIECUS), an interdisciplinary organization founded in 1964 to “establish man’s sexuality as a health entity” and “to dignify it by openness of approach, study, and scientific research.”¹ SIECUS maintains that every comprehensive sex education program should present these six aspects: biological; social; health; personal adjustments and attitudes; interpersonal associations; and the establishment of values.²

Most school authorities are reluctant to commit themselves to a course only, and we think rightly so. If sex education could be limited to a course in reproduction or to one explaining the “facts of life” and these “facts” would meet all the child’s need throughout his school years, giving sex education in one large dose might be practical. But this is impossible, we believe. Sex education should be presented from many angles. It should keep pace with the child: it should grow as he grows and widen as his experience widens.

The idea that sex education should be woven into education from the kindergarten through the secondary schools and should involve all pupils and most teachers has recently gained great momentum. Sometimes, specific units on reproduction are appropriate; at others, information about sex is part of other courses such as home economics, literature, and social studies. Both elementary and secondary schools can show films on puberty in health classes and can hold discussions on reproduction on a level with the age of the pupil. For example, the program offered by the San Diego school system includes sex education in its health education program in grades 6 through 12. Specially prepared teachers provide the instruction, and in junior high school boys and girls are separated by sex for most instruction. The San Diego system has found that separation permits frank discussion of such matters as masturbation and homosexual play. A class at Longview, Wash., did a survey and an analysis of sex slang. Many schools include sex-related topics for discussion in a "senior problem" course. Still others include instruction on attitudes toward and standards for sex in secondary school courses in family living. The Toms River, N.J., high school has had such a course since 1938.

The school system of Anaheim, Calif., provides a 5-week program of instruction in family life and sex education for each grade, 7 through 12. The teachers for the program are prepared through special inservice programs, and the instruction time is taken from that allowed for physical education. Emphasis changes from grade to grade: in the seventh, it is on self-understanding; in the eighth, philosophy of life and ethics; in the ninth, dating; in the 10th, sex standards; in the 11th, communication and solving problems; and in the 12th, family life and child development. Boys and girls attend together.

Since 1946, the high schools of Hayward, Calif., have offered a family life-sex education program in the social studies curriculum running through the entire 4 years. Each student as he enters high school is assigned to a teacher-adviser who will be his "counselor" on all educational and personal matters through his 4 years. This same teacher-adviser will also teach a ninth grade unit in personal adjustment and self-understanding and a 12th grade course in family living for all the students he advises. In this instruction, attention is given systematically to sex information and attitudes. At the same time personal help is available through the counseling relationship the teacher has with the students he advises.

Each school's program will be unique according

to its own needs and the capacity, interests, and inservice training of its teachers. It will change as the school's needs change and as new teachers join the staff and others leave it.

Does this mean that a planning committee's hope for patterning a program on some curriculum as outlined by some other school is illusory? We say, yes and no! It is illusory if the committee thinks it will find the answer to all its problems in the plan of another school; it is real if by studying the plan of another school the committee finds guidance. Each school or community will need to work out its own program.

A few guides giving general directions are available, however. The education and health departments of several States, New Jersey and Illinois, for example, and the school systems of several cities, including Detroit, San Francisco, Denver, and St. Louis, are preparing or have prepared guidelines on sex education and family life programs. The American School Health Association has just issued a document setting forth principles tested by several communities³ that includes suggestions on teaching for each grade, an extensive bibliography, and an annotated list of films and filmstrips. The Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association have published a series of pamphlets on sex education for the schools and for parents. Many Catholic, Protestant, and Jewish groups have prepared materials concerning sex education. The national board of the Young Women's Christian Association has prepared a "sex morality teaching kit" for discussion leaders. And SIECUS publishes guides, reprints of articles, and a quarterly newsletter on new research, publications, and inservice education.

Dispensing with fear

Efforts to start sex education programs run over and over again into the same kinds of fear and uncertainty, the same misconceptions that have hampered effective sex education programs for years, particularly the fear of the sex impulse itself and of harsh public criticism.

The fear of the sex impulse itself originates in the widespread belief that this impulse is extremely difficult to control and will, at the slightest opportunity, express itself in irresponsible, exploitative, damaging behavior. Freudian concepts support this view; our experience does not! We believe rather that hon-

est, objective, open consideration of sex allays fears and curiosity, makes guiding the sexual impulse easier, and works toward a responsible outlook.

Adults often think that embarrassment in a child when sex is discussed means he is "taking it wrong" or is "not ready for so much." But we think it means that he was ready for proper sex education some time in the past but got only the miseducation that is inevitable when fear blocks positive education.

The requests we have received from school officials for carefully graded curriculum material seem to reflect fear. These officials are seeking absolute certainty when they ask what should be taught at each grade level. Sometimes the inability of the "authority" to whom the request is made to be specific is used by school officials to rationalize the contention that "we just aren't ready for sex education."

Parents, too, are often immobilized by the fear of sex and their own ignorance of how to handle the subject with their children, and they carry their fears over when dealing with the school.

Fear of adverse public opinion often hamstrings school officials in their efforts to start sex education programs. They may not realize that most opposition comes from vocal persons representing a small minority. Some critics object to sex education in the school because they fear that, as a consequence, their children will confront them with questions about sex, or they fear that the school is usurping parental rights. Others have a grievance against the school in general, and the sex education program provides a convenient point of attack.

The elementary schools of Bethel District, Eugene, Oreg., after 5 years of work, offer a sex education program that has been strongly supported by parents and community leaders. Efforts to obtain support for the program began when a school nurse held informal discussion groups with parents to help them handle sex education at home. Her work pointed up the need for sex education and led the parents

to request the schools to offer formal sex education. School administrators at first thought that efforts to meet their request would court adverse reactions from the community and hesitated to move. At this point the parents from whom the request had come turned to other parents to get their support. When the administrators found that the public was for the program, they met with the public to discuss what the schools should do. The supporters of the proposed program exhibited salacious magazines along with the one sex education book in the school libraries and showed a film on human growth to parents, who were then asked whether they were for or against showing the film in the schools. The parents voted overwhelmingly in favor.

School officials can often forestall or minimize opposition by involving the community in planning; informing the public in advance of the purpose and objectives of the program; and carefully selecting teachers. When sex education is well handled, the public rarely criticizes. For example, in 4 years the Petaluma, Calif., public school system received only three adverse telephone calls about its sex education program for ninth grade students. In this system the school administrators presented the idea of sex education to the parents and showed one film before the program started. Sensing no objection, they went ahead with the program. Parents were kept informed at the meetings of the parent-teacher association, and students were urged to keep their parents informed about what was going on in class and to show them the books and pamphlets being used. Similarly the Kansas City, Mo., public school system received in about 4 years only two calls critical of its open-circuit television lessons for junior high school students—and these calls were critical of the followup discussion only, not of the broadcasts themselves. The schools made the sex education material an integral part of all instruction and tried no harder to prepare the community for the broadcasts than they would have tried if the material had been on, say, proper dieting.

The best way to obtain public support for a sex education program is through the school's normal relations with the public. The more sex education can be set within the normal program the less it will be singled out as unusual and threatening.

In many localities parent-teacher associations will help explain the program to the community. Or a citizens advisory group may be helpful, for it can speak with more authority and with less defensiveness than school administrators or members of the

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chool board. The school system in Anaheim, Calif., for example, set up a successful family life and sex education program with the help of a citizens advisory group representing a family service organization, the ministerial association, and civic groups. It also holds a yearly orientation meeting for parents during which school officials thoroughly discuss the program with them. This measure has helped offset the influence of a "radio attack" on the program.

We do not favor asking parents to decide whether their children may attend a sex education program. Such a policy implies fear and uncertainty in school authorities and brands sex education as something "different." Sex education should be considered as much a part of the school program as courses in health, English, science, and social studies—in fact, it should be part of these courses, as we have said. If it is an integral part of these courses, why should permission to attend be asked for or granted? Also, who determines when "sex education" is being conducted rather than "health" or "science"? If, however, school administrators feel that the issue of parental permission cannot be bypassed, we favor making it necessary for the parents who object to write the school to this effect. Putting the responsibility on the parents will probably encourage them to give serious thought to the matter before they make a formal request.

Other considerations

Overcoming fear is only one aspect of setting up a sex education program. Other aspects to be considered include teacher competency, whether teaching religion is involved, possible conflicts between the school and the home, the contribution young people can make, the public's expectations, whether to hold separate classes, and the support that can be expected.

Teacher competency. Whenever possible, the school should select teachers with the ability to communicate effectively with children and young people. If they are not prepared when selected to conduct sex education, they can make up for their lack of experience in summer workshops and inservice programs. The training they receive should offer more than just facts, however; it should give them opportunities to analyze their own attitudes and to resolve the problems this analysis raises. Furthermore, school systems are recognizing that a continuing need for inservice programs exists. The Anaheim, Calif., school system has offered inservice training to its teachers since its sex education program began. The schools of

Hinsdale and Downers Grove, Ill., are including inservice education in the plan they are developing.

Experience and research show that effective teachers for sex education programs may come from any field; they may be men or women, married or single, parents or childless.

Is religion involved? Some argue that sex education cannot be conducted in the school because sex education without moral education is dangerous. In their view, moral education cannot be included in sex education because "moral" education means "religion" to them, and the teaching of religion is forbidden in public schools. Yet moral principles governing property, truth, and respect for the rights of others are taught in public schools without involving religion. Sexual morality is no different from the morality involved in other human relations in a society emphasizing responsibility to others.

Developing in the young person the ability to make responsible decisions is one of the most important objectives of sex education. A sex education program for young people, therefore, should present contrasting views on such issues as early marriage, divorce, abortion, family planning, pornography, homosexuality, population control, and the control of venereal disease. A frank discussion of all issues will give young people a basis for making decisions when they are adults.

Home as opposed to school. Does the school usurp the responsibility and rights of the home when it offers sex education? Those who say it does assume that if the school offers no instruction parents can and will do the job adequately, an accurate, realizable assumption in very few cases. But, even were they right, they do not see that the school miseducates if it evades all reference to sex and that it cannot always ignore sex: incidents with sexual connotation occur from time to time in the school and school officials have to respond to them. Moreover, the school, far better than the home, can prepare young people for the wide range in attitudes about sex they will meet.

Sex education programs offered by schools and community agencies outside the home can afford young people opportunities to talk frankly with understanding adults in ways that will improve their self-esteem and hasten their maturity. Such programs can also provide opportunities for young persons to talk among themselves in a wholesome atmosphere, can give them the guidance and knowledge they need to discuss sex among themselves, and can help them internalize a value system based on

democratic interpersonal relations through these discussions.

Participation by young people. We find that including young people in the planning of a sex education program in the secondary school can greatly improve the program. Young people, by their frankness and objectivity in discussions, can allay the qualms of many adults about their attitudes and motivations. We have seen this happen during planning sessions, on youth panels, and in public meetings. Young people can interpret the program to their families and to the community and they can help determine what the program should include. To plan a program without their help may be a waste of time and effort. Adolescents and adults live in different cultures, and there are subcultures within the adolescent world based on race, socioeconomic status, and religious and family background. Program planners can be aware of the special needs of each adolescent group only through young people themselves.

Public expectation. Sex education programs are often "sold" to the public in a way that excites over-optimism about what they can do to reduce the rate of venereal disease, premarital pregnancy, homosexuality, and other ills associated with sex. Although we can all hope that sound sex education will help overcome these ills, their causes are so complex and their roots so deep, it will take far more than sex education to rid us of them. To use data on their prevalence to obtain support for sex education programs without recognizing the social pathology associated with these ills is to arouse false expectations.

Mixed or separate classes? Many people are uneasy about having boys and girls together when sex is discussed. In many schools direct instruction on sex is given by the physical education or home economics teachers because boys and girls are separated naturally in their classes. No hard-and-fast rule can be laid down on the issue of separate instruction, however. Ideally, successful sex education will enable boys and girls and men and women to discuss sex objectively with one another and in groups. However, because boys and girls mature at different ages and teachers vary in their ability to deal with mixed classes and the subject itself, separation for discussion of some aspects is sometimes desirable. In fact, boys and girls may seek opportunities for separate discussions, probably because they feel freer in unmixed groups to discuss such subjects as masturbation, menstruation, and the functioning of the sex

organs. But the need for separate discussion groups should practically vanish by the time students reach senior high school, for the idea that the sexes should be separated because sex is being discussed is outmoded, it seems to us.

Support for sex education. School officials would feel less uncertain about the effects of such programs on the public if they knew how much support for sex education there really is. To illustrate:

Several Federal agencies have been giving active support for some time to programs preparing young people for marriage and family living. The Public Health Service, in its regional conferences, has been urging the schools to offer sex education. The Office of Education makes grants to support programs to prepare teachers for sex education programs and to educational institutions and community agencies to start or to improve programs in family life education and sex education, and last year helped SIECUS hold a national meeting.

Many national organizations are supporting sex education programs. The American School Health Association, at its national meeting in 1966, urged the schools to develop suitable programs of sex education for all children and young people. The American Association for Health, Physical Education, and Recreation has also passed a resolution to the same effect. Several divisions of the National Education Association and the National Congress of Parents and Teachers also have policies supporting sex education programs in the schools, and SIECUS is supporting national efforts to promote sex education.

THE SUCCESS OR FAILURE of these efforts or of any others is determined at the local level. If good public relation principles are followed, if young people and adults in the community are involved in the planning, if the public is fully informed of the scope and purpose of the program, and if teachers have an opportunity to overcome their hesitation, the fear regarding sex education programs can be overcome and a school can offer a good sex education program.

¹ Fulton, Wallace C.: Why is there a Sex Information and Education Council of the U.S.? why a new, separate organization? *Journal of School Health*, May 1965.

² Kirkendall, Lester A.: Sex education. Sex Information and Education Council of the U.S., New York. Discussion guide No. 1. October 1965.

³ American School Health Association: Growth patterns and sex education: a suggested program for kindergarten through grade twelve. Supplement to *The Journal of School Health*, May 1967.

645 DAYS

of MATERNITY and INFANT CARE

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Care for the medically indigent mother and child in most large cities has been, by tradition, provided by two separate services. The obstetrical care has generally been hospital oriented; the pediatric care has generally been given in well-baby clinics and hospital outpatient departments; and there has been little continuity in either. Much of this is changing under the impetus of the maternity and infant care projects for mothers and infants in high risk of morbidity, financed by the Children's Bureau.¹ Each project has its own way of going about providing continuity of high-quality medical care for such mothers and infants. The design in Baltimore, to be described here, was developed to cope with the particular problems in that city. It was based on the theory that continuity of care is necessary from conception through the 40 weeks of gestation, delivery, and in the following months until the infant is 1 year of age—a total of 345 days.

Since 1950, Baltimore has experienced a change in population, with a decrease in the higher social economic portion and an increase in the culturally deprived, medically indigent portion, situated largely in the core of the city. These changes are reflected in the indicators of maternity care. In 1962, Baltimore City maternal mortality was 5.4 per 10,000 live births, as compared with 3.8 for all the counties of Maryland, excluding Baltimore City. Infant mortality was 32.9 per 1,000 live births, compared with 22.6 for the counties. Perinatal mortality was 42.1 per 1,000, compared with 30.5 for the counties. The premature birth rate was 12 percent of all live births in the city, compared with 7.8 percent in the coun-

ties; and in some areas in the city was as high as 30 percent. In 1961, little or no prenatal care was reported for about 30 percent of the mothers living in 19 census tracts in the center of the city.

Efforts to improve maternity care for the low-income population of the city had started in 1954 with the local health department's establishment of a maternity interviewing center staffed by an obstetrician, a public health nurse supervisor, two clerks, and a maternity interviewer (a high school graduate trained by the health department to take obstetrical and medical histories). At that time, the center's physician examined only emergency patients. Others were referred for examination and care to the health department's seven prenatal clinics, the maternity service of the public Baltimore City Hospitals, and the three voluntary hospitals that would serve Negro patients.

From 1954 to 1964, as the other hospitals in the city lifted their racial restrictions, new obstetrical beds became available to Negro patients. Sixteen hospital maternity services—including those of 15 voluntary hospitals—now make no racial discrimination against patients, and these are all participating in the project, as are the health department's prenatal clinics, now consolidated into six.

Mothers in the project can choose among the participating hospitals for delivery—and in some instances for prenatal care—except in cases in which a specific hospital is indicated by a condition found in the mother at the time of her registration and examination at the new maternity center, which was established with the initiation of the project in 1964. For example, mothers with known psychiatric prob-

lems are delivered at hospitals with psychiatric services. About half the mothers in the project receive their prenatal care from the health department's prenatal clinics and are delivered at the Baltimore City Hospitals.

The risk register

The legislation under which the project gets Federal support—the Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act (1963)—encourages the provision of high quality comprehensive maternity and pediatric care for mothers and infants in low-income areas, especially mothers and infants at high risk of developing physical or mental handicaps.² Therefore, the Baltimore project has created a maternal “high-risk register” that lists those conditions known to have had deleterious effects on mothers and infants. This list is used to screen out for special attention—first by the examining obstetrician and then by representatives of the project's nursing, social work, nutritional, and dental staffs—those mothers who have high-risk conditions of any kind. High-risk conditions that develop or become apparent at any time after the mother's registration are reported from the clinics, and appropriate action is taken.

Use of the “risk register” permits clear-cut assignment within the project of responsibility for following through to meet the mother's special needs, whether through the family, community agencies, or the various services within the project. For example, the register clearly indicates that all mothers aged 16 or under, all over 35 having their first pregnancy, all over 40, and all of any age who register late or who have histories of poor clinic attendance must have intensive nursing followup, as must mothers with such chronic conditions as kidney disease, diabetes, malnutrition or obesity, or mental retardation; and that of these groups all mothers 16 or under as well as all mothers who are mentally retarded must see a social worker and all mothers with kidney disease or diabetes must be offered intensive consultation by a nutritionist.

Eighty percent of the 6,243 pregnant women who came to the center in 1965 were found to be at risk for one or more medical conditions. Ten percent were at risk for obstetrical reasons only such as toxemia, pelvic dystocia, previous Caesarean sections previous delivery of low-weight infants, stillbirths or miscarriages. Thirty percent had obstetrical risks combined with medical or social risks. Five percent

had combinations of risks of all three types. Anemia of pregnancy occurred alone in approximately 6 percent of the mothers. Approximately 40 percent of those registering were 19 years of age or under; percent were 15 or under.

With the initiation of the project, the maternit center, its point of intake and the springboard for the 645 days of continuity of care, was moved from its original location in a former city garage to warehouse in the center of the city accessible to all city dwellers. Furnished comfortably to help the patient relax, it has sufficient staff and equipment to make it possible to give complete medical and dental examinations to all registering mothers and to plan a program of followup care for each.

Staff and services

The project's staff includes nurses, nurse midwives, physicians, interviewers, social workers, nutritionist laboratory technicians, health aides, and clerical and statistical workers, some assigned to the center, some to the district prenatal clinics, and some to the hospital clinics. It also includes a health information officer whose job is to make the project's services and the importance of early prenatal care known throughout the city, especially in neighborhoods that have shown poor use of health services.

All expectant mothers who come to the center are given an obstetrical examination by an obstetrician. Those found not to have high-risk medical or social conditions are helped to make appropriate arrangements for their medical care through resources outside the project.

When the patient comes to the center, the first person she sees after the receptionist and the laboratory technician is an interviewer, a nonprofessional person trained to take medical histories. The history is sent in to the obstetrician, who reviews it with the patient, gives her a complete examination, and explains his findings to her. This takes from 15 to 30 minutes.

After the medical examination, the patient sees representatives of whatever other services the initial interview and the obstetrical examination have indicated she needs—social work, dental, nutritional, or financial assistance. Her last interview at the center is with a public health nurse, who makes certain the patient knows where she is going for prenatal care and delivery. The total amount of time required for each case for the obstetrical examination, laboratory tests, the initiation of services, and the making of

arrangements for prenatal care and delivery usually runs from 2 to 2½ hours.

Dental service. Dental services were added to the maternity center in June 1965. The dental suite contains a small reception area, a room with three dental chairs, an X-ray developing area, a recovery area, and an office. The service is staffed by five dentists—one full time and four part time—a dental hygienist, and a dental assistant.

Every high-risk mother has a dental examination on her initial visit to the center. Her mouth is examined, instruction is given her on the proper care of the teeth and gums, and if she needs dental work she is given an appointment for another visit. The clinic does periodontal therapy, fillings, and extractions, emphasizing the prevention of periodontal disease, treatment of gingival disease, and the preservation of teeth. Dentures when necessary are made by private dentists on contract with the project.

The mothers keep their dental appointments better than any other type of appointment.

Nutrition services. The project's nutrition services have been created because the nutritional state of the population of the core of a city like Baltimore leaves much to be desired. Rents absorb much of the family budget and leave little for food. For example, a family of five with an income of \$200 a month may be paying as much as \$100 for a two-bedroom apartment, leaving \$100 for food, gas, light, clothes, and incidentals. Moreover, stores in slums offer food of lower quality and less variety than stores in outlying shopping centers, and their prices tend to be higher. The same kind of meat may be 10 cents more a pound in the Druid Hill central city neighborhood than in the suburbs. Then, the food habits of many people in the slums do not lead to optimal nutrition: they tend to prefer the starchy, filling foods like bread and potatoes to green and yellow vegetables, and cannot easily change their diets.

The nutrition staff consists of five nutritionists. One is always available at the maternity center to provide individual counseling to high-risk patients. In the districts, the nutritionists work with the physicians, nurses, and directly with the mothers in the pediatric assessment clinics, in the postpartum clinics, and in all prenatal clinics.

The dearth of simple nutritional material directed to persons with little reading ability has stimulated the creation of a number of simple pamphlets to explain the basic rules of good nutrition and the modi-

fications in diet required by pregnancy and various other physical conditions. The service has also developed recipes and menus using inexpensive nutritious foods.

The nutritionists have observed that the main nutritional problem of low-income pregnant women is how to obtain adequate amounts of protein, iron, and vitamin C. Forms are being developed to help pinpoint the patients who are lacking in these dietary elements and for what reason.

The project's chief nutritionist attempts to coordinate the nutritional instruction given the patients in the health department and hospital prenatal clinics, a difficult process because it entails the cooperation of the dietitians and doctors at the 16 hospitals. The purpose of the liaison is to achieve continuity in nutritional advice throughout pregnancy.

Nursing services. Because of the heavy demands on the obstetricians and pediatricians manning the clinics and hospital wards used by the project, it seemed not only impractical but also impossible to assign each patient to a specific physician for a continuous followthrough from her first appearance for prenatal care through the first year of her child's life. Thus the decision was made to rely on the nursing services to achieve the goal of providing continuity of care to each patient in a one-to-one relationship with a professional person. This is achieved through the nursing staff of the Baltimore City Health Department, augmented by 30 project nurses. The latter include two nursing consultants—one in maternity nursing and the other in pediatrics—five nurse midwives, one nursing supervisor, and 22 public health nurses. The project nurses are melded into the staff of the city health department's division of nursing, which includes about 250 nurses in all.

The public health nurse assigned to the neighborhood in which the patient lives is the person who provides this continuous one-to-one relationship to

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the patient by visiting her in the home and being available to her through the district health center where the health department clinics are located. Before she leaves the maternity center, the patient is told by the nurse there that the district public health nurse will be her source of help for any problems that arise, whether medical, social, or financial.

To provide continuity of care for patients who receive their prenatal care at hospital clinics, as well as for other patients at the time of delivery, the project has placed "liaison nurses" in the four hospitals caring for the most patients. The liaison nurse has many contacts with the mother and her baby. She attends the hospital prenatal clinics so that she can alert the district nurse to the additional needs of the patient; she is alerted in turn by the district nurse to the special needs of patients coming from the health department clinics to the hospital for delivery. She is aware of the needs of the frightened primipara or the seriously ill patient, and, when possible, she accompanies such patients to the hospital's delivery floor. She visits the hospital's postpartum wards and the nurseries for premature and newborn babies. One of her most important functions is to encourage the new mother to return to the clinic for her postpartum visit and, if the mother wishes, for family planning service.

The nursing service also provides continuity to the project's family planning program. In the maternity center, a volunteer worker from the Planned Parenthood Association acquaints the mother-to-be with the services and methods available. Later, an interested mother has an opportunity to discuss the planning of her family with the public health nurse on home visits, the liaison nurse in the hospital, and again with the public health nurse at the postpartum examination, which is given 4 weeks after the birth of the baby. At that time, if she decides she wants such service, it is given immediately. She has her choice of three methods of birth control. At the present time, "pills" are the number one choice of the patients, but the number of women choosing "IUD" insertions is steadily rising. Foam is available but is not often selected. Patients desiring other methods, such as the rhythm method, are referred to the appropriate clinics. About 4,500 women have received family planning services since the beginning of the project.

The nursing service also provides continuity between the home and hospital in the care of prematures born at the Baltimore City Hospitals. The liaison nurse attends the hospital's conference to evaluate prematures. Here the medical, social, nutrition, and

nursing services are coordinated so that by the time the infant is discharged the hospital staff knows that the home is prepared to receive him and the district nurse has accurate information on how to continue the care of mother and child in the community. The liaison nurse also attends the hospital's followup clinic for prematures. At the end of each clinic session, she meets with the chief of the premature service, the chief pediatric resident, and the hospital social worker assigned to this clinic to discuss the problems of the infants examined.

Usually only about half of the 60 or so babies scheduled for this clinic are brought in. Those who do not appear are given new appointments at the clinic or are visited at home by the district nurse. If the records indicate that the premature infant is developing satisfactorily, his case is referred to the city well-baby clinic nearest his home.

Pediatric services. Pediatric care is provided through the health department's 34 well-baby clinics, nine special pediatric assessment clinics, the participating hospitals' premature nurseries and outpatient departments, and private physicians practicing in the neighborhoods served by the project.

In planning the pediatric services, a second "risk register" was developed. This lists conditions from the mothers' "risk register" not resolved by delivery, conditions arising out of delivery that may influence the infant's development, and conditions that may occur in the next 365 days to change his developmental course. With the help of the district nurse, close followup is made on all babies born to high-risk mothers as well as on other infants with conditions listed on the infant risk register. The most common high-risk conditions found in babies delivered under the project are low birth weight and iron deficiency anemia. "Failure to thrive" occurs frequently enough to be considered a major problem requiring the provision of many coordinated services—nursing, nutrition, social work, psychiatry—and a working together of hospital inpatient and outpatient divisions.

The pediatric record includes pertinent information from the hospital's record made at the time of the infant's birth: information on sex, race, weight, length, head circumference, any physical defect noted in the newborn examination, the Apgar rating (based on observations of the infant at birth and 5 minutes later), results of laboratory tests, and any illness arising in the newborn while in the hospital.

Followup of each infant's progress involves systematic observation and evaluation, with the use of

three forms based largely on forms developed by the Collaborative Perinatal Research Project at the National Institute of Neurological Diseases and Blindness, National Institutes of Health. Two of these forms are filled out by the nurse, the third by the pediatrician. Each time the nurse sees the infant at home or in the well-baby clinic, she uses a form on which she notes illnesses, accidents, or any pertinent events that have occurred since she last saw the infant. This form also provides for notations about the physical and human environment of the home. Thus, it provides the pediatrician who reviews it with important information about the infant's progress and environment as seen through the nurse's eyes. At 3-month intervals the nurse also makes notations on another form, called the development achievement form, which indicates whether the infant has achieved the expected performance level for his age. The reviewing pediatrician can then correlate whatever lags are noted with the prenatal, delivery, and illness experiences of the infant in making a plan for action.

The third form is the 6-month examination form. This is filled out by the pediatrician in whichever of the nine special pediatric assessment clinics the infant is examined. This form is used to assess the child's physical and neurological condition and the mother-child relationship. It is precoded to reduce writing time to a minimum to leave the major part of the physician's time for examination of the infant and consultation with the mother.

All infants with high-risk conditions or born to mothers who had high-risk conditions during pregnancy are given appointments for pediatric examinations at these special clinics at about 6 months of age. A hematocrit is taken on each infant at the time of the examination. The infant is also seen by a nutritionist who counsels the mother concerning feeding. When conditions indicate that special attention is required, the pediatrician refers the case to the project's social services, the nursing division, or a community resource—hospital, physician, or social agency.

Each infant is given a screening test for auditory, motor, and visual defects at about 8 to 10 months of age by the United Order of True Sisters. One method tests both hearing and motor development. Infants who fail to pass this test on two occasions—about 8 percent of all—become "high risks" and are seen by a project pediatrician who decides whether referral to an otological or a neurological clinic is indicated. The visual test is focused on the presence of strabismus. The records are reviewed by an ophthal-



Keeping tabs on baby—a normal procedure with all infants born in Baltimore's maternity and infant care project.

mologist, who sees suspected cases. Thus, treatment can be started early to preserve binocular vision.

Screening for inborn errors of metabolism is confined to efforts to detect phenylketonuria. Each newborn is given the Guthrie blood test before discharge from the hospital, a practice now compulsory in the State of Maryland. In addition, the public health nurse following the child tests his urine with ferrie chloride several times during the following 6 months.

All the forms filled out on the infants are turned in immediately to the maternity center. There the chief pediatrician reviews them along with previously obtained records and makes decisions on what further services are needed. Action in the district can be obtained from the maternity center in a few days—1 day if requested by telephone, 3 or 4 if by memorandum.

At the end of the 365 days, the project pediatrician reviews all findings, noting what lags in development exist and the immunizations and screening procedures the infant has been through; summarizes the events of the year; and, if continued supervision seems to be required, refers the case, with a summary of the findings, to appropriate community services.

Social services. The project's social service section has three major functions: identifying cases with social or family problems requiring special services, referring such cases to appropriate community agencies for help, and stimulating the development of community resources to meet the patient's needs. These functions are carried out by a staff of nine social workers. One social worker interviews at the center all patients having conditions designated for social service attention on the maternal high-risk

register, as well as other patients referred by the obstetrician; one acts in a liaison capacity between the project and the social service departments of the participating hospitals; one works with community agencies to develop the kinds of services needed by the project's patients; one works with the pediatric nursing consultant; and the others work with the nurses in the health districts.

The high-risk register designates for interviews with a social worker at the center the unmarried, adolescent, mentally retarded, alcoholic, or epileptic patients; patients with a history of psychosis; patients who express a desire to give the coming baby up for adoption; and patients with serious financial or family problems.

Many community agencies, public and voluntary, are called upon to bring the patients the services they need, but overall responsibility for resolution of the problems remains with the project. The center avoids duplication of effort by keeping concisely written information flowing to and from the agency or hospital involved. When no community agency is available to provide social casework service to the patient in need of it, as when a hospital to which the patient is assigned lacks a social service department, the service is provided by one of the project's district social workers.

Social needs that arise or first become apparent after the patient leaves the center are referred by the nurses or pediatricians to the project social workers at the district health centers. This happens especially when infants appear to be neglected or mothers exhibit no warmth toward their children or fail to bring them to the clinic—all indications of a deficit in mother-child relationship that may be detrimental to the child's healthy development.

When the child is a year old, a social assessment is made to determine whether the social services provided have improved the outlook for health of both mother and child.

Psychiatric services. From eight to 10 women already diagnosed as mentally ill register at the center every month. Others show symptoms of severe emotional disturbance—often connected with an unwanted pregnancy—or develop such symptoms as the pregnancy advances. A psychiatrist on the project's staff part time works with the obstetricians, nurses, and social workers to help them in identifying, assessing, dealing with, and finding the appropriate treatment for such patients.

Prior to the establishment of the project, the

health department had no means of referring maternity patients to hospitals with emergency psychiatric services. Now four of the project's participating hospitals will accept such emergency admissions, and consequently delays between the outbreak of symptoms and treatment are reduced. In such cases the psychiatrist assumes responsibility for following through with the hospital's recommendations on the patient's release to the community.

Toward evaluation

The project's record system is designed to fulfill three needs: (1) to have all medical, hospital, dental, social, nutritional, and financial information about the mother and infant readily available in one file; (2) to keep pertinent information flowing smoothly between the maternity center and the district health centers and the participating hospitals; (3) to provide statistics that will not only show volume of care but also help in evaluating the service.

A master index with each mother's registration number makes it possible to locate any mother's record in the file within a few minutes. It also alerts the project when records are due from hospital, prenatal, postpartum, pediatric, or family planning clinics, so that patients are not lost to followup care.

The project is gathering data on the occurrence among its patients of maternal mortality, infant mortality, fetal wastage, prematurity, congenital anomalies, and physical and neurological lags in normal development in the first year of life. At this writing final results are not in, but we have some indications that the screening methods used and the high quality of interdisciplinary obstetrical and pediatric care provided through the project have given the infants of high-risk mothers a better chance of survival.

But we know that many infants would have an even better chance of survival if there were adequate community welfare services for patients who are at high risk chiefly because of social problems—as in cases of pregnancy out of wedlock or in adolescence or of anemia stemming from inadequate food intake. To lower such risks, much more has to be done by the community as a whole.

¹ Close, Kathryn: Giving babies a healthy start in life. *Children*, September–October 1965.

² Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January–February 1964.

VOLUNTEERS

in INSTITUTIONS

for DELINQUENTS

ELIZABETH H. GORLICH

● "I just want to write and let you know that I am very pleased with my volunteer visitor and I also want to thank you for making it possible for me to be engaged with such a wonderful person."

So wrote a girl to the superintendent of a California institution for juvenile delinquents. Through the institution's volunteer program, this girl, whose own family could not or would not visit her, had been reassured that someone on the outside cared. After all, the staff is paid for the attention they give; the volunteer gives her attention free—because she cares.

The administrator of this institution has no question about the positive values of using volunteers in direct service to the girls. Unfortunately, however, while much of the standard-recommending literature in the institutional field advocates the use of volunteers,^{1, 2} only a few institutions have well-developed volunteer programs.

The number of persons who work as volunteers in the broad health and welfare field would be difficult to estimate, but a figure in the millions would not be an exaggeration, and the number seems to be increasing.³ There are many reasons why institutions for juvenile delinquents have not fared so well as other

types of agencies in benefiting from their services. Such institutions have traditionally been located in areas remote from the centers of population, thus creating problems of transportation. The children they contain do not attract the sympathy of volunteers so readily as do the children in other programs.⁴ Most people find it much easier to share their time and energy with an abandoned or bedridden child than with a child who causes the community all kinds of trouble by stealing, mugging, or shoplifting. Nevertheless, delinquent children need the warmth, understanding, and personal interest from an adult as much as any other child.

Another deterrent to the use of volunteers in institutions for juvenile delinquents is reluctance on the part of the administrators. Some fear the possibility of conflict arising between paid staff members and volunteers. They know that the staff's failure to understand the role and responsibilities of the volunteer can prevent the volunteer from making as valuable a contribution as he might. Distrust of the volunteer has not only thwarted some volunteer programs but has also caused the potential contribution of volunteers to be underestimated.⁵

The question sometimes raised is whether this potential contribution is worth all the careful planning, interpretation, and supervision required to overcome staff antagonism toward the use of volunteers and help the volunteers to be effective. When the volunteer is regarded as filling a need only a volunteer can fill rather than as just providing an extra hand for the paid staff, the answer can only be in the affirmative. A look at some of the needs of children and adolescents who have been committed to institutions and at some of the ways volunteers have helped meet these needs will indicate how distinctive the volunteer's contribution can be—and sometimes is.

The special contribution

The overwhelming burden of institutionalization, especially for juvenile delinquents, is the removal from normal community life. Most States have only two institutions for delinquents, one for boys and one for girls. This means that the young people committed to them by the courts are removed some distance from their home communities to places where the only people they see daily besides the institution's staff members are other young people who have been adjudicated as delinquent. Their opportunities to relate to persons who live in normal communities are few, yet their need for continued communication with the

outer world is great. Volunteers and staff members bring the outer world into the institution on different bases.

In some places, as in the institutions for juvenile delinquents in California and Massachusetts, volunteers come to the institution just to talk to the young people assigned to them or to lead or take part in some group activity such as hobby clubs, Scout troops, self-improvement classes, and holiday parties. The very fact that they are doing this without being paid for their efforts gives the young people the feeling that someone cares about them. Too often the family, the school, the church, and the community have rejected the young people who have been committed to institutions for delinquents. Some young people never have any visitors from home. For them, regular visits from an interested volunteer can play a major part in counteracting feelings of complete rejection.

But volunteers offer more than friendliness to the rejected youngster. They also provide the young person with a model of responsible adult behavior. Many juvenile delinquents have never been close to anyone who has concern for others. In the volunteer's relationship with them and with the other young people in the institution, they may for the first time become aware of the possibility of caring what happens to persons other than themselves.

In addition to serving the young people with whom they work directly, volunteers serve the institution as a whole by spreading the word about its programs and needs. Any program, whether tax-supported or voluntary, needs community support to function effectively. A volunteer familiar with an institution's programs and problems can become a more effective spokesman for the institution than anyone on the paid staff, for he is less suspected of self-interest.

Despite staff efforts to individualize programs, young people can become "institutionalized"; to prevent this, they need to be away from the institution

from time to time. Therefore, some institutions encourage volunteers assigned to specific children to take them off the institutional grounds—on shopping or pleasure trips—to give them the "feel" of life on the outside. Some institutions have even let volunteers take young people, particularly those soon to be released, into their homes for a day or a weekend to give them a chance to test their ability to live up to the standards of the outside world.

Some pitfalls

With such obvious advantages in the use of volunteers, why do many administrators of institutions for delinquents fail to even try to develop volunteer programs? The answer may be that they fear the pitfalls that can render a volunteer program not only ineffective but actually harmful. These pitfalls do exist, but they can be avoided with careful planning. They lie in the following areas:

1. *The selection of volunteers.* While there may be volunteer tasks of some kind suitable for nearly everyone, this is not true of direct work with juvenile delinquents. Some people cannot work effectively with delinquents because they are so basically hostile to the idea that a young person could behave in the way delinquents do that they cannot give them the warmth and understanding they need. Such persons, however, sometimes do volunteer to help delinquents "reform." For the sake of the program and the young people in it, they must either be turned down or diverted to tasks not involving direct contact with the young people.

Equally to be avoided as candidates for direct work with delinquents are persons who are oversentimental about children. Helping delinquent children requires firmness as well as warmth. Persons who cannot place realistic controls on young people's behavior will end in frustrating both themselves and the young people.

A third type of person to be avoided in selection is the person who cannot discipline himself enough to accept the institution's rules. If a person cannot follow a schedule, keep appointments, or complete training, he will bring more confusion than help to the young person and the institution.

Administrators have found irregular attendance to be one of the most difficult problems in running a volunteer program. Most juvenile delinquents have already experienced so much rejection that they have a decidedly negative attitude toward adults. This

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attitude becomes reinforced when an expected volunteer does not turn up, for the young person who is used to being rejected will interpret the volunteer's absence as another rejection. To protect the young people from such a shattering experience, institutions with volunteer programs have found it important not only to select their volunteers as carefully as they would paid staff members, but also, in orienting and supervising the volunteers they select, to stress the necessity for regular attendance.

Screening out from prospective volunteers those unsuitable for the program and selecting those with warmth, firmness, and dependability require skill in learning about people through the interview process.

2. *Administrative policies.* One reason some volunteer programs run into trouble is a tendency among institutional administrators to give them only half-hearted support. Too often responsibility for the preparation and guidance of a volunteer program is assigned to an already overburdened staff member—often the assistant administrator—who can only give time and attention to the volunteers at the expense of his other responsibilities toward the entire institutional program. The result is frustration on the part of everybody—the administrator, the child-care workers, and the volunteers themselves.

However, when the administrator demonstrates that he is in whole-hearted support of the volunteer program by assigning responsibility for it to a person with both the competency and the time to work closely with the volunteers and staff members toward meshing their efforts, the prestige of the volunteer program is enhanced within the institution and the grounds for its effectiveness are laid.⁶ Unfortunately, few institutions for juvenile delinquents have established either a part-time or full-time position of volunteer service coordinator—a common one in mental hospitals.

Whether or not the institution needs a staff person to devote full time to the volunteer program depends, of course, on its size. A small institution might well assign this function to a person with other duties if these are not so pressing or so numerous as to monopolize his attention; or it might find an administratively gifted volunteer who is willing to direct the volunteer program on a part time basis.

Another way in which an institution's administrator shows his support or indifference to a volunteer program is in his action or inaction in setting clear-cut policies in respect to volunteers who work

with the young people—for example, in relation to insurance coverage, reimbursement for expenses, the use of the institution's cars, accepting or giving gifts, taking a resident off the institution's grounds, the use of case records, the volunteer-supervisor relationship, and procedures for handling complaints. Much confusion is also avoided when specific job descriptions for the volunteers have been established and are periodically evaluated in the light of the institution's needs. Such a procedure gives both the volunteer and his supervisor a clear picture of what is expected of the volunteer in relation to the young people in the institution and in relation to the members of the institution's staff.

Sources of recruitment

In spite of the reluctance some potential volunteers may feel about working with institutionalized juvenile delinquents, a determined director of an institution's volunteer program can find many sources for recruitment if he makes the need and the purpose of his program known to the outside community—especially church groups, volunteer bureaus, service clubs, and other sources of volunteer manpower such as affiliates of national organizations interested in correctional work. For example, the Boy Scouts of America is urging its local councils to establish Scout troops at institutions for delinquent boys and, to this end, has appointed a staff member at its national headquarters to work with the National Association of Training Schools and Juvenile Agencies. The Big Brothers of America has long encouraged the men in its local affiliates to provide personal friendship to boys in institutions or just released from institutions to help them find better ways of relating to the world around them. Similar work is being done by a Kentucky affiliate of the Optimists.

Sometimes volunteers can be recruited because of their special interests or talents. For example, an automobile distributor in an Oregon community is giving driving lessons to the young people in a nearby training school. The Society of Illustrators in New York works with groups of institutionalized boys. Several murals at one of the State's institutions for boys give evidence of this group's contribution to the training school and to the boys' sense of accomplishment. Volunteer musicians have contributed to several New York institutional programs both as entertainers and instructors.

Some institutions are finding new or unusual sources of volunteer manpower, especially for work-

ing directly with individual young people. For example, a Maryland institution has recruited volunteers from a nearby naval installation. Assigned to specific boys in the institution, the Navy men frequently visit them or take them to see the naval center. Separated from their own families, some of the men have indicated that giving friendship to a boy badly in need of a "father figure" gives them a sense of "family."

In California, two correctional institutions are cooperating with the San Diego State College in providing "internships" for sociology students, thereby not only providing the students with a greater understanding of correctional work, but also giving the residents of the institution the benefit of the students' work in group counseling and in occupational and music therapy. Some students have become so interested in the work that they have decided upon careers in corrections.⁷

Students, in fact, represent a large and relatively untapped source of volunteer manpower for institutions for juvenile delinquents. The success in recruiting and using them in mental hospitals and with delinquents on probation suggests that they might serve in juvenile correctional institutions much more widely than they do. In the probation program at Boulder, Colo., for example, college students serve as tutors, interviewers, and discussion leaders.⁸ Because alienated young people usually trust other young people much more than they do adults, another young person can often break through their barriers to friendship more easily than an older person.

There are many other potential sources of volunteers that could be but are not yet being tapped by institutions for juvenile delinquents. For example, Volunteers in Service to America (VISTA) has not yet sent any volunteers to training schools for juvenile delinquents. It has, however, put a number of volunteer teachers in an institution for young offenders (aged 18 to 26) at Lorton, Va., as part of a demonstration project in job training, counseling, and followup being carried out in cooperation with the National Committee for Children and Youth.

There is a trend today to look among the neighborhoods from which delinquents come and even among former delinquents for staff members for projects to

combat or control delinquency.⁹ At least one correctional institution has some of its former residents on its staff as child-care workers. This suggests that ex-delinquents might also provide valuable volunteer service in institutions for delinquents.

Thus the source of volunteers has become the wide American public—and not just the prestigious "upper crust" of Lady Bountiful days. In these times of shorter workdays and workweeks, our communities are full of men and women with sufficient time, good will, and sensitivity to offer creative friendship to young people whose lives have been especially deficient in this essential spiritual nutrient. All that is needed is the catalyst—the institutional administrator with the conviction, courage, skill, and willingness to tap the source.

The Joint Commission on Correctional Manpower and Training, a private organization composed of 96 representatives of various national and regional organizations in the correctional field, has recognized the potential value of volunteers in correctional work by establishing a task force to study the use of volunteers in corrections. This study, now under way, may be an important spur to action.

⁷ Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: Institutions serving delinquent children guides and goals. CB Publication No. 360. Revised 1962.

⁸ National Conference of Superintendents of Training Schools and Reformatories: Institutional rehabilitation of delinquent youth; manual for training school personnel. Delmar Publishers, Albany, N.Y. 1962.

⁹ Thursz, Daniel: Some views on volunteers: past relic or future asset? *Rehabilitation Record*, January-February 1963.

⁴ Kobrin, Solomon: Values and problems in the use of the indigenous volunteer in delinquency prevention programs. In 100,000 Hours a week: volunteers in service to youth and families. National Federation of Settlements and Neighborhood Centers, New York. 1965.

⁶ Phelan, Joseph F., Jr.; Anderson, Virginia: The volunteer as a member of a therapeutic team. *Child Welfare*, May 1963.

⁸ Mecum, Ethel D.: Bringing training school and community together. *Children*, March-April 1961.

⁷ Kirby, Bernard C.; Sher, Daniel L.: An experiment in student internship in corrections. *Crime and Delinquency*, July 1966.

⁸ Department of Health, Education, and Welfare, Welfare Administration: Antidelinquency project measures—effectiveness of volunteers. *Welfare In Review*, March 1966.

⁹ Otis, Jack: Correctional manpower utilization. *Crime and Delinquency*, July 1966.

HOW VOLUNTEERS CAN HELP

disadvantaged children

HARRIS E. KAROWE, M.D.

Many people are skeptical about the ability of nonprofessional persons to work successfully with other people's children, especially when those children give signs of being mentally, emotionally, or socially handicapped. They do not, I think, respect the importance of the intuitive process—the personal sensitivity and perceptiveness through which a gifted person builds up a positive relationship with a child. In his preface to August Aichhorn's book "Wayward Youth,"¹ Sigmund Freud attributed Aichhorn's remarkable ability to work with dissocial boys to his warmth, sympathy, and *intuitive* understanding of them. Freud implied that all of Aichhorn's psychological training had not been of much practical value to him but chiefly gave him some theoretical justification for what he did naturally.

Carefully selected volunteers may be as intuitively gifted as professional persons and often are freer to follow what their intuition dictates. Herein lies their strength. But any person who works directly with children can sharpen his intuition and facilitate his deliberate actions if he understands some principles of helping a child deal with his problems. This is especially true if the person is working with an educationally and socially disadvantaged child whose life experiences have been and are very different from those of the children he knows in his own home or his neighborhood. The following comments are therefore

offered as an elementary guide for volunteers engaged in such work.

What are some of the important elements in helping relationships? Barrett-Lennard,² an Australian psychologist, has dealt with this question in a very useful fashion. First, there is the element of empathy, which means understanding the child from the child's own frame of reference. Empathy is different from sympathy, although both imply a caring for the child. When a person has empathy for a child, he appreciates how the child feels, how things are for him, but he does not make the child's feelings or troubles his own.

Another element cited by Barrett-Lennard as important in helping a child is that of having respect for, of caring for, the child as unconditionally as possible. For the volunteer assigned to help a child with a learning problem, this means showing him he is respected as an individual despite his learning disability. This is done by showing compassion without being over-emotional, by being understanding but not indulgent, and by showing genuine regard for the child's development.

The achievement of continuous and complete respect, of course, can be only a goal; and it is not one which anyone can hope to attain. But one can, at least, compliment a child unconditionally when one does compliment him and not say, "That's good, *but*. . . ." However, in the long run, the less a relationship with a child is overrun by evaluation and judgment, the more the child will be able to reach the realization that the center of responsibility lies within himself.

Another element in a helping relationship men-

Adapted from a talk made at a meeting on school volunteers sponsored by the Onondaga County Mental Health Board and the Syracuse (N.Y.) School District, October 1965.

tioned by Barrett-Lennard, perhaps the most important of all, is trustworthiness. This means being genuine, dependable, and internally as well as externally consistent. To understand why consistency is so important in working with a child, it is necessary to know a little about how children learn to relate to other people from their earliest infancy on.

Of consistency and hope

Engel³ has remarked that soon after birth the infant begins to show cyclical behavior. The sleeping baby gradually changes from being quiet and motionless to showing restlessness and some sucking motions. Then his level of awareness rises, his movements increase, and he awakens and begins to cry. If his mother picks him up, he may quiet down, but soon he will cry again and he will not be quieted until he is fed. During feeding he sucks actively for a while, and then his sucking begins to slow down and finally, as he achieves satisfaction, stops. He becomes quiescent again: he may be wakeful for an interval between satisfying his hunger and falling asleep, but then he is quiet for a few hours until his feeling of need awakens him again and the cycle is repeated. In this process the infant uses the most primitive form of communication, his cry, and this elicits a response from his mother, who by feeding him introduces the external world into this otherwise entirely internal cyclical process.

But in a few weeks the sight of the mother's face and the sound of her voice become enough in themselves to quiet a hungry, crying baby, even if only for a minute or two. This is important: the baby has shown the beginning of his capacity for anticipation: he has begun to be able to wait; there is now a future, not only a present. Thus begins the development of one of the most important functions of the ego, the ability to interpose delay between the awareness of a need and the acting upon that need. Something that is not directly a part of nutrition has become an anticipatory signal indicating that satisfaction *will* occur. As this experience happens over and over again, the baby develops *confidence* in the signal, or in this early symbol, that tells him his discomfort, hunger, will be followed by satisfaction. And out of this confidence, with further psychological growth, the baby later develops *hope*.

The basic instinctual need, that of satisfying hunger, is of course only one kind of childhood need. As the child develops, his needs become increasingly complex, but they always include the element of

consistency in his world—and his world is composed of the people around him. Consistency is a quality characteristically absent in the lives of children of seriously deprived families—as is also its end result hope. Children in such families, and their parents, frequently function as if there is no hope, no confidence, no future. Hence they tend to brook no delay in gratification of desires.

Consistency is therefore of utmost importance in working with a child. To be of value to the child a volunteer must be consistent in his attitudes most of the time, though not always, for that is impossible.

Being truly consistent means being honest and not pretending, at least with oneself. As Michal-Smith says, to make the child feel that one is dependable one does not have to be a model of virtue, or loving at all times, or *entirely* consistent in mood, or ready to gratify the child's every need and wish. Everybody feels different on different days; this makes it impossible to have the same attitudes on every day. To try to convince oneself that one feels accepting of a child when in fact one is feeling annoyed or hostile is being internally inconsistent. Sooner or later this inconsistency will be perceived by the child and will be interpreted as untrustworthiness.

The important point is to be aware of whatever feeling or attitude one has when working with a child. When a person is not aware of his feelings he is likely to send out contradictory messages: the child, confused, does not know whether to believe the kind words or the not-so-kind tone of voice or expression. "Her talk is a whisper, but her looks yell at you," said Dennis the Menace to his buddy in a recent cartoon depicting the two children outside a library from which they have obviously just been ejected by the librarian who stands grimly at the door.

In working with a child, of course, a person cannot tell or act out all his true feelings. But he can become as aware as possible of what his true feelings are. Then he can integrate these with his conscious at-

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itudes and so lessen the contrast between expressed and unexpressed attitudes. When this is done, both the adult and the child feel more at ease with one another. True consistency lies in inner honesty, which the child perceives and feels as dependability.

Deprivation and learning

Children fail to learn well for a variety of reasons—neurological, neurotic, characterological, and social. I shall comment here chiefly on the last kind, since the children whose difficulties stem from social reasons are those most often assigned to volunteers for help.

There seems to be a relationship between school adjustment and whether or not a child's mother is employed outside the home.⁵ However, it has been found that the mere fact of the mother's working is not the important difference between the children who do well in school and those who do not, but rather the mother's motives for working and her attitude toward the child and the school.⁶ It also has been found that a negative attitude in parents toward school, an attitude occurring more often in parents of low socioeconomic status than in middle class parents, is related to children's poor academic performance.⁷ When the values of family and school are contradictory, children have little incentive for school achievement.

There also is evidence that the material environment in the home has an effect on pupil performance, that a varied environment and a *variety* of stimuli during early development favor greater use of the child's intellectual potential.⁸

The volunteer can make a significant contribution in both these respects. In broadening the variety of stimuli, the volunteer's contribution is chiefly one of activity, of doing things with the child. But in counteracting the deleterious effect of the child's perception of his parents' negative attitude toward school, the relationship between the child and volunteer is itself the important element. In this respect, of course, the volunteer does what the good teacher does: he furnishes the emotional reward and support for school success that encourage the pupil to like and do well at school despite lack of support at home for his scholastic efforts.

Deutsch⁹ has pointed out that language is the primary avenue for communication, absorption, and interpretation of the environment. Between the ages of five and eight, children begin to use words as instruments in their conceptualization: a language

handicap at that time may become a handicap in general problem solving. Deutsch also notes that the active verbal engagement of the people who surround the child seems to be the influential force in the child's language development.

Bernstein¹⁰ points out that in many families of low socioeconomic status language is used largely in a restrictive fashion. An imperative or an incomplete sentence frequently substitutes for an explanation or a complete sentence: if the child asks for something, too often he gets merely "yes," "no," "go away," "later," or just a nod or a shake of the head. Moreover, many such families have few, if any, organized family activities; the parents and children do little talking together at meals, for meals are seldom regularly scheduled affairs.

Deutsch found that by the fifth grade children from fatherless homes generally score significantly lower on IQ tests than children from intact homes: however, this may be not so much a consequence of the father's absence as of the diminution of organized family activity in fatherless families.⁹

Deutsch's study of language ability and usage in first- and fifth-grade children, white and Negro, lower and middle class, indicated that the language deficit among children of low socioeconomic status was cumulative. While significant differences according to race and to socioeconomic status existed in the first-grade children, these differences were more marked by the time the children were in the fifth grade. However, the language of children from families of low socioeconomic status is poorer not in quantity, but in complexity; it does not have an elaborated sentence structure with grammatical order, logical modifiers, frequent use of prepositions, impersonal pronouns, and discriminately selected adjectives and adverbs. It therefore is out of tune with what the children meet in school.

Deutsch suggests that these children as they first come to school are aware of their grammatical ineptness, and that this leads to reluctance to communicate across social-class lines and hence to reticence in school.

The volunteer can interfere with this breakdown in communication and help prevent the child's language from becoming class contained. He can do this merely by talking *with* and *to* the child in the kind of language expected of the child in school. The volunteer will find it useful, however, and perhaps even necessary to become acquainted with the language used in lower socioeconomic neighborhoods.

Pavenstedt¹¹ has reported on an admirable study

of family life in lower socioeconomic groups. She found that the style of living among the stable "upper-lower class group" (factory workers, house painters, truck drivers, and so forth) was very different from the style of living among the disorganized families identified as the "lower-lower class." This latter group, in which unemployment, separation, desertion, divorce, abandonment and neglect of children, and dependency upon public aid are most frequent, furnishes our schools with children who very frequently fail to learn. These are the children badly in need of the personal help of volunteers.

On superficial examination, it might not be easy to distinguish between the children of Pavenstedt's two groups. They came from the same neighborhood and were equally well dressed. But their lives had been radically different. Pavenstedt's vivid and moving description of the disorganized families and the way of life they endure points up the innumerable deficits in their lives of which the volunteer needs to be aware in working with such a child. Excerpts from her report follow:

... The outstanding characteristic in these homes was that activities were impulse determined; consistency was totally absent. The mother might stay in bed until noon while the children also were kept in bed or ran around unsupervised. Although families sometimes ate breakfast or dinner together, there was no pattern for anything. . . . We saw children crying from some injury dash into the apartment, run past mother to their bed and continue to scream there. The mothers seldom inquired about their injuries or attempted to comfort them. Ridicule was as likely to be the response. . . .

... None of the children owned anything; a recent gift might be taken away by a sibling without anyone's intervening. The parents often failed to discriminate between the children. A parent, incensed by the behavior of one child, was seen dealing a blow to another child who was closer. Communication by means of words hardly existed. Directions were indefinite or hung unfinished in midair. . . .

Children in such an environment have to learn to cope for themselves, and these children were extraordinarily adept in certain areas. Extremely skillful at reading their cues, they focused on adults and manipulated them so as to obtain the attention, praise, food, money, or whatever else they wanted. . . .

... The children masked pleasure by clowning and grimacing and showed no distress when hurt. They wore wide smiles quite inappropriately. When disappointed or angry, they would fade away. When upset or anxious, they might become paralyzed or engage in some frantic repetitive activity. Nevertheless, many of them, surprisingly well dressed for nursery school, had a certain charm.

Many of them formed their words so poorly that it was at first almost impossible to understand them at 3 and 4 years of age. Words were used imitatively and often quite out of con-

text. Instructions, when attended to, were at times repeated but not translated into action. Concrete demonstrations were necessary. . . .

The saddest, and to us the outstanding, characteristic of this group with adults and children alike was the self-devaluation. One little boy, when encouraged by the teacher to have her put his name on his drawing, wanted her to write "shitty Billy." Their lack of confidence in their ability to master was painfully reenacted with each new encounter. . . .

... The children seemed to have no individual personality for the parents. They never learned to trust and were constantly on the alert for the adults' reaction. Without anyone to relate to, they failed to learn communication and came to grips only with certain very circumscribed areas of their reality. . . .

... In large classes with their extreme concreteness of thinking, they failed to grasp directions. Suspicion and anxiety concerning the adult's intentions made them unable to attend to the teacher's instructions. As failure followed failure, they grew very anxious and shunned any learning task. . . .

Pavenstedt points out that the first priority in helping such children may be to raise their parents' self esteem, for only then can they find value in their children—and only then will their children be able to sustain feelings of self-confidence and self-esteem. There is great truth in this, but I also believe that until this is accomplished the children need direct personal support and help from another adult as well. And here is where the volunteer comes in—with attention to the child, his words, and his unvoiced wishes, with consistency and warmth, and in many instances with real liking and love.

Some warnings

Cytryn and Uihlein¹² give some special warning to volunteers working with children who have special handicaps. Like the teacher, the volunteer has to avoid becoming unrealistic in his expectations. He cannot expect success with all children. He has to try to avoid feelings of hopelessness and futility provoked by the overwhelming nature of the child's problem or because the child does not respond. Moreover, he needs to keep in mind the impulse-ridden pattern of some children's lives, their inability to tolerate delay, their orientation toward the present and toward immediate rather than future gratification, their essential lack of hope and of confidence. He has to wait for the trusting relationship to develop and then, as the child slowly begins to identify with him, for some of his own personality characteristics to be unconsciously adopted by the child.

For some children the volunteer can provide a "corrective emotional experience"—the volunteer

who is a woman can become a warm mother-substitute for the child of a severely emotionally disturbed mother such as one who is schizophrenic or very depressed or very obsessive-compulsive. Or, for the child of an overpossessive, overprotective, or anxious mother, a volunteer can furnish a close one-to-one relationship without the intense, smothering emotional involvement the mother offers.

In any case, the volunteer needs to avoid excessive emotional involvement with the child, something that certainly can occur and that may manifest itself in a tendency to monopolize the child or in a fear that the teacher or the parents will spoil his good work with the child. On the other hand, the parents—and sometimes the teacher too—may distrust the volunteer or may fear criticism by the volunteer. A mother who is not close to her child may resent the volunteer's ability to get close to the child as well as the child's obvious enthusiasm for the volunteer. Of course, the volunteer has to be aware of the possibility that he is indeed unconsciously vying with the parents or with the teacher for the child's affection. Most people, adults as well as children, love to be loved.

Sometimes, in the initial contact with the child and for as long thereafter as necessary, the volunteer can offer a "surprise" type of emotional experience by virtue of having a personal relationship with the child. For example, the failure to learn by *some* children—though generally not the children of the lowest socioeconomic groups—is a passive-resistive measure against parental pressure *to* learn. When assigned to help such a child learn to read, the volunteer might shock the child at the outset by avoiding all mention of reading. The child thus discovers that he is acceptable in spite of his unwillingness to read. He may thus, in his increasingly close relationship with the volunteer, come to put into words, rather than into a passive-aggressive failure to learn to read, his hostility toward his parents and toward the teacher who by virtue of her professional

position *must* direct herself toward his reading—and then he may be ready to give up his symptom of hostility to adults, his failure to learn. This kind of volunteer treatment might never be called psychotherapy, but its success would be psychotherapeutic nonetheless.

The volunteer has a special advantage in his relationship with a child, an advantage that generally redounds only to the psychiatrist. As a psychiatrist, I have always felt that I am in a very special position. What adult other than a psychiatrist ever gives a child his undivided attention for a whole hour—and does it not once but again and again? Well, volunteers may do this too—and in a way that can play a key role in the child's life.

¹ Aichhorn, August: *Wayward youth*. The Viking Press, New York, 1935.

² Barrett-Lennard, G. T.: Significant aspects of a helping relationship. *Mental Hygiene*, April 1963.

³ Engel, George L.: *Psychological development in health and disease*. W. B. Saunders Co., Philadelphia, Pa. 1962.

⁴ Michal-Smith, Harold: It takes self-understanding. *NEA Journal*, April 1960.

⁵ Burchinal, Lee G.; Rossman, Jack E.: Relations among maternal employment indices and development characteristics of children. *Marriage and Family Living*, November 1961.

⁶ Sussman, Marvin Bernard: Needed research on the employed mother. *Marriage and Family Living*, November 1961.

⁷ Luszki, Margaret Barron; Schmuck, Richard: Pupil perceptions of parental attitudes toward school. *Mental Hygiene*, April 1965.

⁸ Hunt, Joseph McVicker: *Intelligence and experience*. Ronald Press Co., New York, 1961.

⁹ Deutsch, Martin: The role of social class in language development and cognition. *American Journal of Orthopsychiatry*, January 1965.

¹⁰ Bernstein, Basil: Language and social class. *British Journal of Sociology*, September 1960.

¹¹ Pavenstedt, Eleanor: A comparison of the child-rearing environment of upper-lower and very low-lower class families. *American Journal of Orthopsychiatry*, January 1965.

¹² Cytryn, Leon; Uihlein, Audrey: Training of volunteers in the field of mental retardation—an experiment. *American Journal of Orthopsychiatry*, April 1965.

Some of the disadvantaged children have reality-oriented strength of survival and independence which middle class youngsters might well learn.

A public school teacher as quoted in "Equality Through Integration: A Report on Greenburgh School District No. 8," Anti-Defamation League of B'nai B'rith, New York, 1965.

● three years of the ● NEIGHBORHOOD ● YOUTH CORPS

REGINA H. SAXTON

● Three years ago this summer, through the Economic Opportunity Act of 1964, Congress established the Neighborhood Youth Corps (NYC) to provide work experience and training to young people from low-income families. Through March 1967, the program had provided work experience for 910,946 young people: 589,424 who were still in school; 321,522 who were out of school. Of the total, 518,095 were boys and 392,851 were girls. For many young people, this experience has led to the realization that if they are to get on in the world they should go back to school, and they have done so, and some have stayed on to the finish. For others, the experience has led to regular jobs in the community—even to careers. Some, unfortunately, have landed back on the streets, again disillusioned. What has happened to all these young people has, of course, had something to do with the young people themselves—their determination, their stick-to-itiveness, their motivation. But most of all, perhaps, it has had to do with the kinds of opportunities that were available—at school, in their community, and in their Neighborhood Youth Corps assignment.

The goal of the Neighborhood Youth Corps is to provide young people with options through which to secure a better future. They may, while remaining in school, earn income and through the work they perform gain valuable experience. They may, if already out of school, receive special training to help them develop their occupational potential. These opportunities are provided through three types of projects:

1. *In-school projects*, to help high school students

stay in school until graduation by providing them with part-time work, up to 15 hours a week during the school year, and with counseling to help them understand the importance of continuing their education and, at the appropriate time, to help them make the transition from school to work or occupational training.

2. *Summer projects*, to provide part-time summer employment, averaging about 26 hours a week for 12 weeks, for young people who need to earn some income during vacation in order to return to school or who need summer jobs to enhance their employment potential.

3. *Out-of-school projects*, to provide young people who have left school with work experience that will increase their employability or help them see the importance of returning to school for more education.

The pay in all Neighborhood Youth Corps projects is at least \$1.25 an hour. Ninety percent of the cost of each project is met through Federal funds. For the first 2 years the program was limited to young people between the ages of 16 and 22, but under the 1966 amendments to the Economic Opportunity Act the lower age limit has recently been dropped to 14.

The degree to which the Neighborhood Youth Corps program makes a significant difference in the lives of young people depends not only on the young people themselves but also on the commitment and concern of the citizens in each local community. For, while largely federally financed, the projects are community planned and community run. The sponsors are local, private, nonprofit organizations and



No longer a school dropout, a Neighborhood Youth Corps enrollee is being taught to repair typewriters—a skill that will give him a chance to become self-sufficient and productive.

local and State governments that have entered into agreements with the U.S. Department of Labor to establish NYC projects.

In the agreement with the Department of Labor, the sponsor specifies the programs in which the enrollees will work, the jobs they will perform, the supervision they will receive, and the enrichment services that will be provided them. In communities with community action agencies established under the "war on poverty," the Neighborhood Youth Corps project is usually an integral part of that agency. Where no community action agency has been formed, the sponsor may be a local council of social agencies, a local "Y," or a local or State welfare, education, or health department.

The enrollees

Enrollees in the Neighborhood Youth Corps must come from families whose incomes are under the poverty line—\$3,000 a year for a family of four. Thus, it is not surprising that enrollees from minority groups—Negroes, Spanish-speaking Americans, and Indians—comprise over 50 percent of the enrollment,

for the share of "poverty" among these groups is disproportionately high. About 60 percent of the Negro youth in this country come from families below this "poverty level." Moreover, unemployment is higher among Negro youth than among white youth. As of March 1967, in the 16- through 19-year-old age group, the unemployment rate for white boys was 10.1 percent, and for white girls, 9.2 percent; but for non-white boys, it was 24.8 percent, and for nonwhite girls, 24 percent.

In their personal attributes, enrollees are the young people of America in microcosm. They are responsive and apathetic; interested and disinterested; bright and slow to learn; industrious and indifferent; idealistic and cynical; courageous and afraid. They include young people who believe enough in themselves to make maximum use of their Neighborhood Youth Corps experiences. They also include the poorly motivated, the apathetic, the uneducated, the victims of generations of discrimination. The latter are the young people who present the greatest challenge.

The special targets of the out-of-school phase of the program are the disenchanting young people who have come to believe that school for them will open no doors to a better future. They frequently shield their tender hopes of what they can become behind a facade of apathy and cynicism, called "lack of motivation" by the adult world.

Jerry, a Neighborhood Youth Corps enrollee with whom I talked recently, expressed it this way:

I found out why John don't want to go back to school; because he is a dropout. If he goes back, he is going to drop out again, because they are going to offer him the same thing they offered him before.

You go to a job nowadays, they've got wall-to-wall carpeting; they've got beautiful pictures on the walls. You walk in the door. The man stands there. He is looking at you through his nose and he hands you a bunch of papers for a test.

He throws you in a room. You come out of the room. He says, "Okay, go, we'll call you later." Now I mean, this is cold. This is really cold. I mean, as far as I know, he don't want you at all.

Many young people like Jerry cling to the "hollers" of Appalachia, meander the rural roads that dot the countryside, and "hang around" on the city streets—dropouts not only from school but often from society itself. Many are not sufficiently attracted by the NYC program to take the first faltering steps toward finding out what it is all about and how it can help them. But thousands *have* taken the first steps, and these have been assigned work that otherwise would not have been done, in public and private nonprofit organizations, most frequently schools and health and

social agencies. While on the job, many have received personal counseling, remedial education, and other supportive services from local community agencies that have been integrated into the projects locally.

We now know that 54 percent of the out-of-school young people who leave the Neighborhood Youth Corps do so to take jobs or specialized training or to return to school full time; 2 percent leave to enter the Armed Forces.

Work and supervision

The kind of work that enrollees perform is limited only by the needs of the community, the imagination of the sponsor, and, of course, the ability of the enrollee. For example, in Roanoke, Va., enrollees in the out-of-school project are working as auto mechanics' aides, laboratory aides, maintenance aides, neighborhood workers' aides, nurses' aides, office aides, storekeepers' aides, teachers' aides in nursery schools, vehicle service aides, and X-ray laboratory aides. Those in the in-school projects are working as auto mechanics' aides, clerical aides, draftsmen's aides, food preparation aides, hospital orderlies, librarians' aides, and teachers' aides. In addition to these typical job classifications, NYC projects during the past year have included conservation and beautification aides, youth and community service aides, and police aides.

Two major requirements for project approval are: (1) the jobs need to be done; and (2) the enrollees are supervised, either by a regular staff member of the sponsoring agency or someone especially employed for the purpose. Often the work is routine, but when this is so in a well-thoughtout and well-supervised project it is planned to lead to more demanding and satisfying tasks. Undoubtedly, however, some of the enrollees' assignments hold less potential for developing a transferable skill than others.

Last summer, through the impetus of the summer opportunity campaign initiated by the President's

Council on Youth Opportunity, sponsors of NYC projects received money to take on additional NYC enrollees for placement in "Operation CHAMP," a nationwide program to provide organized athletics and other recreational activities for children and young people and, at the same time, work for thousands of young jobseekers. In some instances it stimulated NYC enrollees to think about pursuing careers in the recreational field.

One enrollee wrote to a project sponsor:

While working in this new program, Operation CHAMP, I have learned to understand things more vividly—children are very easily led and we NYC's are a great influence on them. I have never really held important responsibilities because I've never worked before. But this job gave me a degree of leadership and independence. Working with the children brought out my ability to work with an open mind. I found that while working it brought out a value of my maturity and it helped me to control myself as well as the children.

Another enrollee, after working in Operation CHAMP, wrote his project sponsor:

This year I decided to step my foot out into the world and make something of myself.

Many ongoing community programs have also provided satisfying work experiences to NYC enrollees. For example, a young woman from a small mid-western town recently wrote the sponsor of a project:

I started to work through this organization because I wanted to know if I really wanted to be a nurse. They got me on at the hospital, and I decided my future while my job helped pay for my high school education. I know now that I probably will become a nurse when I graduate.

Unfortunately, not all NYC enrollees have had such constructive experiences. Some have been placed in jobs that are "made work" offering little promise of increasing their employability, and some have been working under mediocre supervision.

A major aim of the program is to help young people become self-propelling who, because of deprivations in their past, cannot sell themselves, cannot read, and cannot communicate well. This takes more than just giving them a chance to earn \$1.25 an hour for 32 hours per week at a necessary but routine job. A young person so handicapped needs to be buttressed by understanding adults with whom he can identify and with whom he can talk over his own self-doubts. Experience has shown that an adult who supervises such young people on the job needs to know much more than how the job should be done. He needs to know how to teach a skill to an untutored adolescent and how to help another human being experience success in doing a job well. This requires

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of the supervisor a degree of sensitivity and skill beyond that usually required in work supervision. How far the NYC supervision lives up to this ideal varies with the projects.

Supportive services

Important allies to sensitive supervision in helping a young person to grow through an NYC experience are the supportive services provided through the projects with the aim of increasing the enrollees' employability or their interest in remaining in or returning to school. These services vary with the projects in number and quality, and their long-term effectiveness is often related to what else the community has to offer the young person when he leaves the project. Counseling and remedial education are the services most frequently provided.

Services have been found to be most effective when they have been designed to complement each other in a way that makes it possible to meet the individual enrollee's need. In other words, the work experience, the job activity, the training, and the supportive services bear a dynamic relationship to one another. As the enrollee progresses, some services are added and others are dropped. For example, take the experience of Johnny, a 17-year-old Philadelphia boy, as reported by the sponsor of the NYC project there:

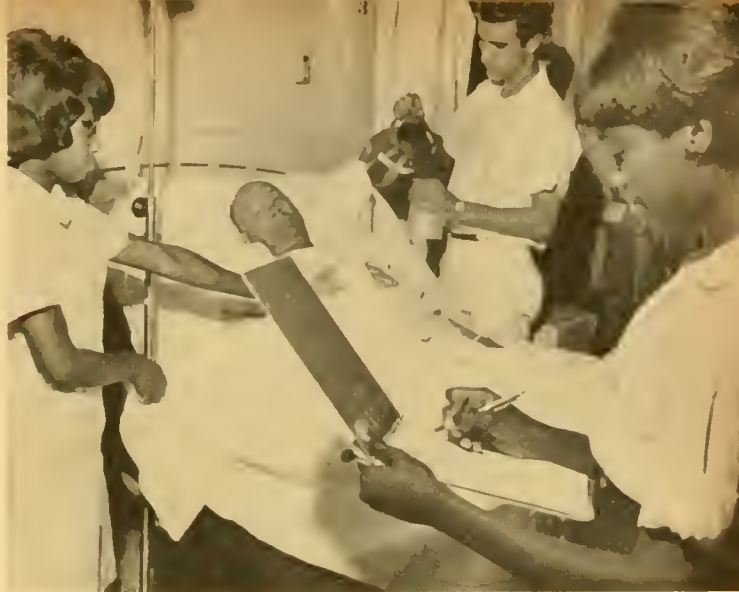
When the Houston Community Center started a unit of the Neighborhood Youth Corps, Johnny was assigned as a community service aide, helping VISTA volunteers in their community programs. The NYC counselor talked with Johnny about his need for training. He was subsequently referred to the State Bureau of Vocational Rehabilitation (Johnny had lost the sight of one eye in a gang fight), and this agency paid for Johnny to take courses at a technical school that trained draftsmen.

Johnny completed his time with the Neighborhood Youth Corps. He was still discouraged. He was not sure if he was good enough to fill a drafting job. His counselor arranged a job interview and went with him to the interview. He was hired as one of the two draftsmen in a small electronics firm, making a good salary.

Johnny is now married and has a child. He likes both his job and his bosses, and he is proud of himself.

Since this report was made, Johnny's employers have asked him if he would like to go to engineering school at night. They, along with others, have assured him that he can succeed there if he decides that is what he wants.

The kind of support Johnny received has unfortunately not been available to the NYC enrollees in all projects. However, the Department of Labor is now insisting on the integration of supportive services into the projects. Thus many more young people



While ministering to the comfort of hospital patients, these three Neighborhood Youth Corps trainees are acquiring skills that may lead to permanent careers in the health services field.

may be able to break out of the cycle of poverty and self-distrust which enchains them.

Perhaps the aspect of service most frequently neglected in the local NYC projects is the provision of health services. Although the Federal Government will pay \$10 per enrollee toward health services, based on the use of existing resources, few projects thus far have given much attention to the health needs of enrollees. One notable exception is in Berkeley, Calif. There the sponsoring agency established a budget to provide for medical examinations of the 165 enrollees, all between the ages of 16 and 22. The results, analyzed in a report by Dr. Victor Eisner, of the University of California School of Public Health, showed that 40 percent, or 66, required no medical care; 18.8 percent, or 31, required only dental care; 25.5 percent, or 42, required medical care; 15.7 percent, or 26, required both dental and medical care. Thus, 60 percent of the enrollees needed health care they were not getting.

Among the conditions needing attention were severe respiratory infections, hypertension, venereal disease, and dental problems—all conditions affecting efficiency on the job. Unfortunately, there has been no followthrough within the project to see that the needed care is provided in the community.

Most of our large communities today have many resources for medical care available, many of them supported by various types of Federal aid, but young people in need have difficulty finding their way through a maze of uncoordinated services. By calling

on a combination of these resources in a creative way, a local NYC sponsoring agency would be carrying out a major aspect of its responsibility to enhance the employability of NYC enrollees.

Some sponsors have been creative in mobilizing available community resources to work with them to provide opportunities to enrollees. For example, the Sacramento, Calif., sponsor has reported that—

- The McClellan Air Force Base provides work training for enrollees and facilities for use in their orientation and education.

- The local department of education provides free health examinations to each enrollee.

- The county provides three teachers to conduct regular school courses once a week leading to a high school diploma and to give remedial school work to those who need it.

- The YWCA also provides remedial education and individual counseling as well.

More and more sponsors are succeeding in relating community resources to each other and to the enrollee. Others have provided opportunities for work training but have been frustrated in their attempts to make connections with the local institutions.

However, even where there are good supportive services, a constructive NYC experience may come to naught when the basic community institutions do not provide what these young people need at the time they leave the program. Many enrollees, for example, return to school as a result of positive experiences in an NYC project, but they do not always remain in school. A project in an eastern industrial city, with 250 enrollees, succeeded in getting 147, or 59 percent, of them to return to school, only to have 112, or 76 percent, drop out again before the end of the school year. One suspects that they found in school the same drab experiences that they had previously fled.

Job development

Similarly, enrollees often do well in the program but flounder in seeking subsequent employment. However, those projects which, like the Philadelphia project, have built up some interest in local employers have been able to help their “graduates” to success during that critical period of job hunting which can mean the difference between a continued growth in self-confidence or a sinking back into despair.

Nevertheless, it has been all too clear that efforts to create bridges to permanent careers for NYC enrollees have needed to be greatly strengthened. Some

important steps in this direction already have been taken nationally.

Experience in an NYC assignment might in a sense be compared to “basic training” for a new recruit in the Armed Forces: it provides the basic training for working on any job. When NYC enrollees finish their assignments, many of them need further training in more complex occupational skills to be ready for career-type jobs—jobs that provide more than the minimum wage and a chance to move upward. To assure them of this opportunity, the Manpower Administration of the U.S. Department of Labor has in the past year tightened the coordination, at all levels of operation, between the Neighborhood Youth Corps and the Manpower Development and Training Program (MDTA), thus making it possible for a young person to go from the Neighborhood Youth Corps to vocational training under the MDTA or even to participate in both programs at once.

Other opportunities are provided under the 1966 amendments to the Economic Opportunity Act which set up three new manpower programs: Special Impact Program, New Careers, and Operation Mainstream, the first two of which will be closely coordinated with the Neighborhood Youth Corps. The Special Impact Program will focus on work training for young people and adults in neighborhood improvement programs in low-income urban areas. Operation Mainstream will provide work experience and training for adults with histories of “chronic unemployment.” The New Careers program holds the most promise as a career outlet for young adults who have had NYC experience, for its goal is to demonstrate the effectiveness of permanent nonprofessional jobs in the human services, particularly health, education, and public safety, classified in a way that will provide opportunities for progression in pay and responsibility. The program is open to unemployed adults of 22 or over from families with incomes below the poverty line.

These amendments also make it possible to place NYC trainees in profitmaking organizations and in this way should increase the opportunities for young people to work from their NYC assignments into permanent jobs in industry. Some large industries have already given preferences to NYC enrollees in hiring people for entry jobs, for example, Quaker Oats, Burroughs, General Motors, and Ford.

In some States—Illinois, Michigan, Missouri, for example—through the efforts of both the NYC staff and project sponsors, exceptions have been made in State civil service requirements for NYC enrollees.

In other situations, the NYC experience in a government job assignment is equivalent to a more formal training period and therefore may be substituted for education or experience. The U.S. Department of Defense has used NYC enrollees and in some cases has upgraded them as permanent civilian employees. However, civil service eligibility requirements still present blocks to NYC placement in Federal jobs.

Effects and promise

As Secretary of Labor W. Willard Wirtz has said, "The ultimate success of the Neighborhood Youth Corps will not be measured in terms of the numbers of enrollees but only by the number of them we have standing up and who stay standing up."

It would take a tremendous research project to find out what ultimately happens to the more than 900,000 young people who have had NYC experience. But there can be little doubt that experience in the Neighborhood Youth Corps has been a positive force in the lives of many thousands of young people in this country. For many, perhaps, it may have been the turning point from an antisocial to a constructive orientation to society. Reports are coming in from many communities of a decline in delinquent behavior among those young people reached by the program. For example, a city recreation director in Covington, Ky., has observed:

Since NYC, property destruction in our city playgrounds has shown a fantastic decrease and is now quite negligible. I might also add that the general crime rate in our city prior to May 1965 was showing a steady increase in the 16 through 21 age bracket. Happily, since NYC, the city's crime rate has been on the decline overall, more markedly however in the 16 through 21 age bracket. In my view, the net positive result has been (1) more effective utilization of the recreation dollar with less having to be spent to replace material, equipment, and facilities caused by the high rate of vandalism; (2) beautification of parks and playgrounds that are now more attractive and also safer to visit and use than previously; (3) less need for police work in these areas; and (4) most importantly, the youths themselves could see their accomplishments and feel the inner satisfaction about their work. I believe some, for the first time, could sense that they were building themselves up rather than allowing their lives to be destroyed. They were beginning to prove to themselves and others that the unemployed school dropout could become a useful citizen in his own right and perform a useful service to the community.

The community action agency in San Antonio, Tex., SANYO, released a report in February 1967 indicating that in slum areas, where it has some 30 neighborhood centers employing NYC enrollees, juvenile delinquency declined 12.6 percent in 1966. In

some areas in San Antonio where SANYO does not operate, there was a 5.5-percent increase in juvenile delinquency during that same period. Although the county as a whole showed a decrease in delinquency in 1966, the report states, "... it was only the fantastic reduction in the poverty areas that accounted for the overall countywide decline of 3.7 percent." County probation officers have made an effort to place as many juvenile offenders as they can into the SANYO program.

In May 1966, the Neighborhood Youth Corps held a conference in St. Louis, Mo. Among the delegates were 130 young people who were enrolled in NYC projects coming from all regions of the United States and from Puerto Rico and the Virgin Islands. Asked to look ahead with the staff and chart a course of action for the Neighborhood Youth Corps that will go beyond anything yet accomplished, the young delegates formed a committee, which reported in part:

There should be a pretraining period to prepare new enrollees for jobs they have been assigned. They should also have more opportunity to move from job to job to gain experience to enhance their human relations and their ability to get along with people, and to increase their knowledge of the world of work.

Thus the enrollees themselves put their fingers on some of the missing links in many of the projects. In doing so they demonstrated the importance of involving the young participants in planning. In recommending rotation from job to job within a project—for example, from laboratory aide to teachers' aide to mechanics' aide—they recognized one of the greatest potential values of the Neighborhood Youth Corps: giving the young person a chance through close association with a variety of occupations to learn what they really involve, thus providing him with a sound basis for choosing the direction of a future career. A number of larger projects are now doing this.

In the last analysis the Neighborhood Youth Corps can never be anything to the young person but a chance—a chance to know what working means, what kinds of occupations there are, where they lead, and what it takes to get ready for them, but most of all a chance to build up confidence in one's ability to perform a useful, necessary job—in other words a chance to participate in what Thomas Wolfe has called the promise of America: "to every man the right to live, to work, to be himself, and to become whatever thing his manhood and his vision can combine to make him—this, seeker, is the promise of America."¹

¹ Wolfe, Thomas: *You can't go home again*. Harper & Brothers, New York. 1934.

BOOK NOTES

THEORIES OF CHILD DEVELOPMENT. Alfred L. Baldwin. John Wiley & Sons, New York, 1967. 618 pp. \$8.95.

Seven theories of child development are examined and compared in this book: what the author calls the "common-sense theory" and the six "scientific" theories of Lewin, Piaget, Freud, Werner, Parsons and Bales, and the stimulus-response theorists (Bandura, Dollard, Hull, Miller, Sears, Skinner, Walters, and Watson). The author begins with a description of the "common-sense notions" of behavior and development, which he sees as the foundation on which other theories are built. He then compares the six "scientific" theories with each other and with the common-sense theory.

The "scientific" theories overlap very slightly and "talk past each other," he says. This fact suggests to him that an "eclectic integration of the theories" is possible if the language each uses can be reconciled, and that "a kind of proto theory of child development," which, though incomplete, badly defined, and "surely wrong in some respects, is a feasible . . . basis for further research and for more refined theory building."

DEVIAN'T CHILDREN GROWN UP: a sociological and psychiatric study of sociopathic personality. Lee N. Robins. The Williams & Wilkins Co., Baltimore, Md. 1966. 340 pp. \$11.50.

This book reports on a study comparing over 500 adults in the St. Louis area who as children had been referred because of deviant behavior to child guidance clinics with over 100 adults whose childhood behavior had been considered as normal.

The author finds that the best predictor of sociopathic personality in these adults would have been the degree to which they had exhibited antisocial behavior in childhood. He points out that by all his criteria the adults who as

children had been referred to clinics for antisocial behavior were much more maladjusted than were adults who as children had been referred to clinics for other reasons. The latter as adults were actually much like the adults who had had normal behavior in childhood. The maladjustments of the former showed up in high rates of arrest, occupational failure, hospitalization for mental illness, divorce, alienation from family and friends, and alcoholism.

The author maintains that poverty alone is not responsible for antisocial behavior but rather the "salient characteristics of family structure in the matrix of poverty." Many of the sociopathic adults involved in the study, for instance, had had fathers with the same characteristics and they seemed to be passing on these characteristics to their own children. The author recommends, therefore, that society plan for early treatment of children showing sociopathic traits.

The author is a research professor of sociology in psychiatry at Washington University School of Medicine.

TWINS AND TWIN RELATIONS. Helen L. Koch. The University of Chicago Press, Chicago, Ill. 1966. 302 pp. \$6.95.

Nearly three-fifths of the 90 pairs of 5- or 6-year-old twins whose characteristics this book discusses were born prematurely, the author points out. And, she maintains, the handicaps of prematurity rather than any inherent weakness in twins may account for the poorer health and less keen mentality of many of the twins she studied as compared with a control group of boys and girls born singly. All the twins were attending regular classes in public schools and were the only children in their families. They included both fraternal and identical boy twins and girl twins and fraternal boy-girl twins. The conclusions the author presents are based on interviews with the children's

mothers and teachers and with the children themselves; on tests for mental ability and apperception given the children; and on ratings given by the teachers on the children's social behavior.

Other observations the author makes about the twins include the following:

- The twin born first was usually the larger and healthier of the pair.

- Although the boys are usually less sturdy than the girls, the boys of boy-girl twins were usually born first and were in better condition than their sisters.

- Rivalry between twins did not seem higher than that between children born singly in other families.

- One twin dominated the other in about 61 percent of the cases, usually through social ability rather than brute force.

- Twins were more popular with their classmates when they attended classes together, probably because of the attention twins often get.

CHILD WELFARE SERVICES. Alfred Kadushin. The Macmillan Co., New York, 1967. 625 pp. \$9.95.

Prepared for use in both graduate and undergraduate courses and by practicing child welfare workers, this text book centers on three types of welfare services for children: supportive (such as family services, child guidance, and protective services), supplementary (such as day care, homemaker services and social insurance), and substitutive (such as foster care, adoption, and institutional care). Each section includes a history of the service, descriptions of case studies, an evaluation of each service, and references to research literature. The concluding chapters are on services in other countries and on social work as a career. The author points out that his aim is to develop knowledge about, concern for, and understanding of child welfare services, not professional skill.

READINGS IN THE PSYCHOLOGY OF PARENT-CHILD RELATIONS. Gene R. Medinnus, editor. John Wiley & Sons, New York, 1967. 371 pp. \$4.50.

This collection of research reports reprinted from 33 professional journals are presented under six headings: methodology; parental attitude and behavior; parental influence; parents in the children's eyes; effects of social class and effects of cultural practices.

an essay review . . .

a
focus
on



CHILDREN
OF THE
POOR

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● It was inevitable that the grand inquiry prompted by the rediscovery of poverty in the sixties should have moved income maintenance policy to center stage. Why has so much poverty escaped the social insurance net? Why have our massive income transfers not lifted more people out of poverty? Has our social security system, in fact, been conferring more benefits on middle class people than on the poor? Has the public welfare system, designed for the poorest, been binding them to continuing deprivation? Why has the indignity of poverty in the midst of affluence been reinforced by the indignities of welfare program procedures? And why are the children particularly disadvantaged when one might have supposed that they would be the preferred beneficiaries of our social welfare efforts?

In the years following passage of the Social Security Act, coverage under the

old age and survivors insurance program was extended, additional risks were included, and qualifications for benefits were liberalized until only a tenuous attachment to the labor market and nominal "contributions" were required for entitlement. Thus, through modification of original principles social insurance benefits came to be more easily acquired than was originally planned and more widely distributed. But entitlement as a right has remained unimpaired, and the receipt of pensions or hospital services is free of stigma.

This improvement in old age and survivors protection for insured workers was not paralleled by equally liberal developments in the public assistance program on which the poorest families have had to rely, families consisting of children deprived of the support of a father, with their mothers or other "caretakers." Indeed, this Federal-State program, Aid to Families with Dependent Children (AFDC), fell into disfavor and even became a vehicle of discrimination against children. The approximately 3.5 million children dependent on AFDC today receive far less than do the adult recipients in other federally aided programs. Moreover, rigid restrictions on "eligibility" leave out most of the 15 million children who have been estimated to be living in poverty.

Contradictions in policy have haunted the AFDC program from the beginning. The social welfare community has been well aware of the dysfunctional and disincentive characteristics of the laws providing for this program and of their administration and of the poverty imposed on the recipients. Yet, in 1962, the basic physical needs of AFDC families were apparently judged to be less urgent than their need for rehabilitation: in that year Congress provided Federal support for expanded social services but failed to remove the built-in discrimination against children in the Federal reimbursement formula for cash assistance.

This neglect of children and the policy alternatives available for ending it is what Alvin L. Schorr's new book, "Poor Kids: A Report on Children in Poverty,"* is about. An appreciation of its

contribution can be better understood by a reminiscent look at the road we have been traveling.

The background

The search for effective antipoverty policy has been conducted under increasing pressure from the civil rights movement, the persistent and unequal distribution of unemployment, the problems of urban life, and the fear that automation would make unskilled and semiskilled labor obsolete thus condemning large numbers of unskilled, uneducated persons to chronic unemployment on a scale that could be coped with by no less a change in our economic system than the separation of work and income.

The public debate that shaped the development of today's antipoverty policy as well as criticism within the social welfare community raised questions about the debilitating effects of relief levels, the degrading nature of the means test, and the rights of social welfare beneficiaries. Eligibility determination procedures were branded as socially wasteful. AFDC caseloads were seen as being too large; public welfare staff as in short supply; individualized calculation of budgetary deficiencies as too expensive.

Moreover, there was growing disenchantment with the quality and quantity of services that qualify for 75-percent Federal reimbursement. It began to be suggested that rehabilitation of program and policy might take precedence over rehabilitation of the client. So, in a new context, there evolved a new version of the theory that public welfare is one of the sources of the poverty it is supposed to relieve, that it helps to fasten the shackles of "intergenerational poverty" on its clients, that its rules stifle incentive and inflict disabling indignities through application of "suitable home" and "man in the house" regulations.

Public discussion of the issues identified a cluster of objectives with which it might be possible to reconstruct the public welfare function, including: more dignified treatment of the recipient; agency and worker caseloads small enough to permit meaningful delivery of social services; relief standards at least up to the defined poverty line; determination of eligibility through simplified and reason-

*Schorr, Alvin L.: *Poor Kids: A Report on Children in Poverty*. Basic Books, Inc., New York, 1966. 205 pp. \$5.95.

ably impersonal procedures. Thus, a climate of opinion receptive to the introduction of new methods of income maintenance was created.

Most attention has been captured by the most glamorous of the proposals designed to compensate for lack of income, namely, the guaranteed minimum income (GMI), a term that expresses aspiration and goal rather than specific plan. The particular device through which the GMI may be attained and that has in turn captured attention is, of course, the negative income tax (NIT). Simply stated, the NIT proposes to use the Internal Revenue Service to pay income (or negative taxes) to families whose income is so low that they qualify as "tax receivers" rather than as taxpayers. It is not always clear to what extent the various advocates of NIT see it as a supplement to, or substitute for, the social insurance and public assistance programs, or if, indeed, they have considered the possible effects of its coexistence with these programs.

The social goal of setting a national family income minimum inheres in any income maintenance policy; it is implicit whenever social assistance is provided in any systematic way. It could, therefore, be achieved through existing public welfare programs. But since these programs are prime targets of criticism by the advocates of GMI, it seems that their objective is to achieve not only higher relief standards based on presumed average need for all who fall below the official poverty line, but also new terms of entitlement ranging, with the various advocates, from a liberalized and humanized test of need to universal entitlement without test of need and based only on some demographic characteristic.

The "demogrant," as such a universal allowance is called, has the advantage of not stigmatizing the recipient because it separates need from benefit. The poor and the nonpoor would be treated alike. Some NIT advocates, however, have much more modest goals.

Focus on "kids"

Alvin Schorr makes a valuable contribution to this debate. The focus of his concern is not so much GMI as "poor kids" and what we have to do to bring a coherent social policy for families into being. He is not uninter-

ested in the GMI, but says, rather, "let us begin"—by first turning our attention to meeting the needs of the children in poverty.

The deprivation of children is intolerable to Schorr. He, therefore, maintains that antipoverty policy should give priority to children. In effect he then asks: What are the life conditions of poor children, and what means do we have for lifting them out of poverty and insulating them from its damaging effects? What means are available for providing support to families at those vulnerable points in their lives where the "income squeeze" catches them and inflicts irreparable damage?

In a powerful chapter, "The Family Cycle and Income Development," Schorr lays the basis for consideration of what a family support policy might be. He takes a simple cost-benefit approach to analyzing the relative merits of NIT, insurance against the risk of family breakdown, and a universal demogrant for children. He is concerned not only with the most practical way of reducing poverty but also with how to do it so as to shield the family from disintegrative social and economic forces. He looks for the flexible, preventive device, designed to relieve income stresses as they appear in the life cycle of the low-income family.

A policy instrument

To attain these goals, Schorr concludes that the most effective device is the children's (or family) allowance. This is a device for spreading some of the costs of child rearing in use in most industrial countries. Canada has had a system since World War II that pays all families \$6 to \$8 per month for each child under 16. For this country, Schorr proposes a preschool allowance of \$50 per month payable for each child under 6 and financed out of general revenues. He sees much of the State and local portions of assistance expenditure thus saved, thereby making it possible to divert these funds to improve public assistance for older children through higher money payments and an expansion of public social services.

A children's allowance system is a singularly useful instrument in the development of social policy for the family. It avoids the disincentive problem because it flows to all families, regardless of the parents' level of earn-

ings. It provides more income without changing the relative positions of wage earners of different skills; work effort always increases income by the full amount of earnings. It meets the problem of the wage-earning heads of families whose earnings are no match for their family responsibilities. Hence it serves to reduce the disadvantage of the child in the large family.

Since 60 percent of our poor children, as Schorr points out, are members of families with four children or more, this system would be a powerful instrument for achieving welfare goals. It could divert a portion of our national income to the poor in a dignified manner. At the same time it could reduce caseloads of public welfare departments to more manageable proportions, thereby permitting them to concentrate on the provision of social services to children and their families unimpeded by eligibility determination

About costs

Demogrant, such as children's allowances, are sometimes opposed because they are not restricted to those who "need" them and are therefore more expensive than benefits precisely adjusted to need. However, social insurance also delivers income to those who do not "need" it, and this is one reason for its popularity. Moreover, the United States does have a restricted form of children's allowances, exclusively reserved for those who do not need them. They are provided as tax subsidies only to those who have sufficient income to pay an income tax, and hence the largest benefit goes to families who need it least. The value to a family of dependent's exemption ranges from \$84 for a child of the poorest tax payer (one in the 14 percent tax bracket) to \$420 for a child of parents with the highest incomes (in the 70 percent tax bracket).

The cost of adopting a universal children's allowance system without reference to need runs high, even if we allow for the sums that would be recaptured by income tax and saved by the elimination of dependency exemptions. The nonfinancial benefits are less tangible and difficult to measure and translate into monetary terms, but are real nonetheless. Because receipt of benefits is not dependent on the family's willingness to undergo a test of need, no child

n need is left out. The removal of stigma is also an important benefit to poor families.

Almost everything in the life of the poor—housing, consumer goods, medical care, public services—is poor in quality and a standing accusation of personal failure. Even the public school, historically the first social utility for all children, has been deficient in what it has delivered in basic and vocational education to the poor. Thus, the higher costs of benefits divorced from need may be regarded as a necessary price to pay for a reduction of inequality; the poor and the nonpoor would not be set apart.

An income transfer program of the dimension here implied (Schorr offers a more conservative prescription) will not solve all the problems of children. An initial program might not do more than prevent gross deprivation. How fast we move would depend on the extent to which we are willing to transfer income from the childless members of

society to those with children to support, from the rich to the poor. But even with such a transfer the greatest gains in eliminating poverty in the country must come through economic progress as parents become fully employed. Historically, such progress has been the great reducer of poverty. Hope therefore lies in economic expansion planned to encourage upward pressure on wages, downward pressure on unemployment, and pressure in all directions against want and squalor.

Schorr, in his treatment of the problem of children in poverty, directs analysis toward the "big" proposals, but he does so in the context of the needs of low-income families at different points in their history and in awareness that if there is basic provision, then a range of options are opened from which supportive family services can be chosen.

Should we not, then, be examining the comparative costs and benefits of household grants to start young fam-

ilies, housing subsidies on a scale sufficient to contribute widely to family welfare, maternity grants, subsidies to reduce the prices of milk and children's books, vacations and work opportunities for adolescents? And is there not something absurd about imposing, as we do, a combined social security-income tax of about \$250 a year on the employed head of a young family of three with earnings of \$3,150 a year?

There is more than one way of increasing family income. What we do to and for poor families is made up of many different components, often contradictory. Therefore, many different lines of attack are possible. Whether or not one agrees with Schorr's particular formula, those concerned with the children of poverty and with the welfare of all children will join the search for new policies. One can do no better than to start with "Poor Kids," which presents the issues with the creative imagination that we have learned to expect in Schorr's work.

guides and reports

THE SOCIAL WELFARE FORUM. 1966: official proceedings; **SOCIAL WORK PRACTICE**, 1966: selected papers, 93d annual forum of the National Conference on Social Welfare, Chicago, Ill., May 29-June 3, 1966. Columbia University Press, 2960 Broadway, New York, N.Y. 10017, for the National Conference on Social Welfare. 1966. 249 pp. \$6; 216 pp. \$6, respectively.

The first volume contains selected papers concerned with trends and issues in developing policy in social welfare; the second, selected papers dealing with developments in theory and application in the methods of social work practice: casework, groupwork, and community organization.

THE DAY AFTER SUMMER: a report on the Conference on Planning for Washington's Children and Youth, October 18-20, 1966. Dorothy R. Stefens, Summer Planning Committee,

Washington, D.C. 1967. 72 pp. Limited copies free on request from the United Planning Organization, 1100 Vermont Avenue NW., Washington, D.C. 20005.

Summarizes the work of a conference devoted to an evaluation of summer programs provided children and youth in the District of Columbia in 1966 and the development of plans for more effective and comprehensive summer programs for the future.

MOTHERS-AT-RISK: the role of social work in prevention of morbidity in infants of socially disadvantaged mothers. Perspectives in Social Work, Vol. 1, No. 1. Florence Haselkorn, editor, Adelphi University School of Social Work, Garden City, N.Y. 11530. 1966. 126 pp. A limited number free on request.

The proceedings of an institute co-sponsored by Adelphi University School of Social Work and United Cerebral

Palsy Associations, Inc., with a grant of maternal and child health funds from the Children's Bureau.

REPORT OF THE COMMITTEE ON SCHOOL HEALTH OF THE AMERICAN ACADEMY OF PEDIATRICS. American Academy of Pediatrics, P.O. Box 1034, Evanston, Ill. 60204. 1966. 128 pp. \$2. Discount on orders of six or more copies.

Presents guidelines for school administrators and physicians on the essential components of school health programs and the roles of the participating physician and school personnel in carrying them out.

RECREATION AND SOCIALIZATION FOR THE BRAIN-INJURED CHILD. Sol Gordon and Risa S. Golob, editors. New Jersey Association for Brain Injured Children, Central New Jersey Section, 61 Lincoln Street, East Orange, N.J. 07017. 1966. 110 pp. \$2.

Presents guidelines for planning and organizing therapeutically oriented recreational and socialization programs for brain-injured children.

HERE and THERE



Juvenile delinquency

The Supreme Court of the United States, by an 8-to-1 decision, ruled on May 15 that the constitutional guarantee of due process of law is applicable to court cases involving minors charged with being "delinquents." In a detailed opinion, written by Justice Abe Fortas, the Court ruled that in delinquency hearings before juvenile court judges children must be accorded the constitutional protections of due process in regard to the right to remain silent, to receive an adequate notice of hearing, to counsel, and to confront witnesses, and the privilege against self-incrimination. That is, they must be given specific notice of the charges and adequate time to decide on a course of action and to prepare a defense; be clearly advised of their right to counsel and be provided with counsel by the State if the parents are unable to afford a counsel; be warned that their testimony can be used against them; and have an opportunity to face their accusers.

Justice Fortas made clear, however, that the decision applied only to the trial of a juvenile and would not affect the handling of juvenile cases before or after trial. The decision states that the "high crime rates among juveniles . . . could not lead us to conclude that the absence of constitutional protections reduces crimes, or that the juvenile system, functioning free of constitutional inhibitions as it has largely done, is effective to reduce crime or rehabilitate offenders . . ." But, he added, ". . . the features of the juvenile system which . . . are of unique benefit will not be impaired by constitutional domestication."

The case on which the decision was made involved a 15-year-old boy accused of making obscene telephone calls while on probation. No notice was left

at his home of his being picked up by the police and taken to a children's detention home, though both his parents were at work. No notice of the hearing was served on the parents, though the mother was informed verbally by the police. The complainant did not appear at the hearing, and no record was made of the proceedings. The judge committed the boy to a State industrial school for his minority "unless sooner discharged by due process of law." (An adult tried for the same offense would have been fined from \$5 to \$50 or sentenced to 2 months in jail.)

Child welfare

The Commission on International Social Welfare of the National Association of Social Workers (NASW) recently wrote to the President of the United States to express the association's concern over the proposal of a citizens' group to bring war-injured Vietnamese children to this country for medical treatment. The letter, signed by James R. Dumpson, the commission's chairman, pointed out the danger in such a proposal of overlooking the right of every child to be brought up in his own family and in his own culture and of violating good child welfare principles. It urged the President to appoint a group of experts to help the Vietnamese determine the best way of attaining better family and child-care service in South Vietnam and pledged its full support to such a group.

Any plan to help the children of Vietnam, according to the commission, should be based on the following principles:

- The greatest effort should be directed to reuniting children with their own families.
- Institutional care of children outside the family should be considered

only as a last resort and a temporary measure.

- Children should only be removed to other countries for needed service in exceptional circumstances, and then all human rights of the children, including the right to return home, must be firmly protected.

- Under no circumstances should children and their needs be used to influence political opinions in regard to U.S. involvement in Vietnam.

In fiscal year 1967, the Children's Bureau awarded \$5½ million in child welfare training grants, in the fifth annual series of such grants since their authorization under the 1962 public welfare amendments to the Social Security Act. These grants to institutions of higher learning to train social workers for the field of child welfare include 741 traineeships to support graduate education leading to a master's degree in social work and 47 traineeships for training beyond the master's or study leading to the doctorate degree.

Teaching grants were made to 67 schools of social work to employ 17 faculty members.

Grants were also made to fund 2 short-term training projects which include seminars, workshops, institutes and conferences.

The poor

To provide a means of disseminating the findings of its research on the urban poor, the Health and Welfare Council of the National Capital Area, Washington, D.C., has established a project Cross-Tell, under the direction of Luther P. Jackson. Cross-Tell is concerned exclusively with issuing and interpreting the findings from a now completed council-sponsored project the Child Rearing Study (CRS) of Low Income Families in the District of Columbia, carried out by a team of anthropologists, sociologists, and social workers between 1960 and 1964 under the direction of Hylan Lewis. For both projects the council received support from the National Institute of Mental Health.

The materials of the CRS project include participant-observer reports, taped interviews, and detailed descriptions of family life and interpersonal

relations among the lowest socioeconomic portions of Washington's population. From these materials, Cross-Tell has thus far issued four publications. The most recent, "Culture, Class, and Poverty," contains three papers by Dr. Lewis pointing out some general implications emerging from the study.

The other publications are: "Three Generations," by Camille Jeffers, which employs case materials in the words of a single low-income family; "Telling It Like It Is!" which is in the form of a drama with dialog drawn from verbatim interviews with CRS respondents and as the basis of a performance given last September by the actors Ossie Davis and Ruby Dee at Howard University; and "Poverty's Children," by Mr. Jackson, which presents some main CRS findings, often supported by the respondents' words.

Cross-Tell publishes an occasional newsletter providing information about research relating to the urban poor. It also holds institutes and seminars for students and practitioners in the "helping professions."

The CRS publications may be obtained from Cross-Tell, 95 M Street S.W., Washington, D.C. 20024.

For youth

By the end of April, many national voluntary youth-serving agencies had plans well underway for expanded programs for young people this summer. They reported on these at a meeting in New York on April 27, called by the National Social Welfare Assembly at the request of Vice President Hubert H. Humphrey. Participants included representatives from 35 voluntary agencies, the Office of the Assistant Secretary (HEW) for Individual and Family Services and the Children's Bureau (delegated representatives of the Office of the Vice President), and the Office of Education's New York regional office.

Among the agencies that reported plans to expand *residential camping* facilities were: The Boys' Clubs of America, which will have facilities to accommodate 15 percent more campers than in 1966; the Boy Scouts of America, which will take non-Scouts from 11 cities into its camps; the National 4-H Clubs, which will provide camping for 158,000 young people of low-income

families; and Encampment for Citizenship, which will operate three encampments for about 360 campers, 70 of whom will be from low-income families.

Some agencies also reported plans to step up *recreational programs within the cities*. For example, the Girl Scouts of America, as part of its program Special Area Services, will operate day camps for girls in the inner city and include transportation to and from camp. The Boys' Clubs of America will increase operating hours of club facilities from 25 to 50 hours a week, on a 7-day basis; expand its recreational program; and extend the operating hours of its 115 indoor and 100 outdoor pools and add portable pools in 20 to 30 locations. The National Recreation and Parks Association will enlarge its "Life Time Sports Program" started in 1966 to operate in 111 locations with the expectations of reaching over a half million young people, as compared with last year's operation in eight locations for 84,000 young people.

A number of agencies reported plans to increase opportunities for youth participation in *volunteer services*. The Young Men's Christian Associations' National Council Student Department will recruit and place 500 more student volunteers than in 1966: some will work in Operation SPECTRUM (a program in which college students help inner-city residents with their problems), which has been extended to 11 communities; 40 will work in the Appalachian area; and 1,800 will work on the Indian Reservation at Rosebud, S. Dak., and in the Cal-Tech Project, which focuses on problems of rural, migrant Mexican-Americans living on the Mexican border.

The American Red Cross will expand Project REACH (teams of eight to 12 youth working with two adult leaders to provide programs and services in communities), to be 10 times larger than in 1966. The National Federation of Catholic College students will send about 200 student volunteers to work in the Christian Appalachian Project in McKee, Ky., to help residents learn to develop woodshops, greenhouses, and other facilities as a means to gain economic independence.

The Commission on Youth Service Projects has published a directory of opportunities for volunteer work in the human services for high school and college students. The U.S. Youth Council

is preparing a list of 10,000 college students who are willing to work in community service programs in the inner city this summer.

Many *summer employment opportunities* for young people will be provided through the agencies. For example, the Boys' Clubs of America will provide job opportunities for about 2,500 boys in its clubs and 2,500 in its camps, as well as job opportunities for Neighborhood Youth Corps workers in 25 to 30 camps and in six or more clubs. The National 4-H Clubs is working with State employment offices in an employment oriented project in which about 194,000 young people will have opportunities to acquire skills in landscape gardening, child care, auto mechanics, tour conducting, caring for animals, and operating tractors.

Child health

A research conference on the problem of dyslexia (impairment of reading ability) and related disorders, supported by a Federal grant from the Office of Education, was held May 15-16, at Southwest Texas State Teachers College, San Marcos, Tex. Among the 26 persons who attended were neurologists, pediatricians, child psychologists, geneticists, speech pathologists, audiologists, and educators. The purposes of the conference were to assess the state of knowledge about dyslexia and the scope of the problem and to make recommendations for attacking it.

Conferees reported that prevalence of dyslexia ranges from 1 percent to 20 percent of the population, depending upon whether the term is used broadly to cover reading difficulties from any cause—including sensory impairment, emotional problems, mental retardation, eye dominance, deprivation of cognitive stimulation in early childhood, or specific brain or neurological impairment affecting word perception—or narrowly to include only the last named cause.

The educators pointed out that about one-third of the school children have some degree of reading difficulties, though not all are severe enough to be labeled as dyslexia. Stressing the importance of careful diagnostic evaluations to determine the etiology and help classify the nature of the reading difficulty more precisely, the conferees recommended the initiation of a nationwide action program, combining medical and

educational efforts to provide remedial programs for both preschool and school-age children.

. . .

Over the next 3 years the University of Colorado Medical Center at Denver will test the hearing ability of about 450 infants and children under 5 years of age by conventional methods and by a new method using a computer to determine the effectiveness of the new method and to develop guidelines for its use. The computer analyzes brain waves recorded by an electroencephalograph (EEG) after eliminating all but those emanating from auditory activity. This, the center expects, will give the new method advantage over conventional methods of testing hearing that, because they require the subject to respond, cannot be used effectively with young children or with persons who are uncooperative. The National Center for Chronic Disease Control, U.S. Public Health Service, is sponsoring the testing program.

The children whom the Denver center will test will be drawn from those screened by local hospitals and clinics and from patients referred by private physicians in Colorado and surrounding States. Plans call for about 150 children to be tested each year, about 75 percent of them under 2 years of age and about 15 percent from 2 to 4 years old. The guidelines are being prepared to enable audiologists and otolaryngologists to determine the degree of hearing loss in children by reading brain waves.

. . .

If lead poisoning from the ingestion of paint—still a problem among children living in the slums of old cities—is to be prevented, concerted efforts must be made to eliminate environmental exposure to lead-containing paint and to treat pica (the desire to eat nonfood substances). So concluded the participants of a Symposium on Management of Chronic Lead Intoxication in Children, held in Baltimore on April 24, 1967, by the Happy Hills Hospital, a nonprofit convalescent facility for children in Baltimore. About 175 public health workers, including nurses, social workers, and physicians, attended.

In speaking of the ultimate effects of the disease, Dr. Randolph K. Byers, of the Children's Hospital of Boston,

told of a followup study of 45 children who had been hospitalized for lead poisoning in which seven were found to have persistent psychological irregularities, eight were found to be retarded, and four to have died. In another group he cited, all the children after diagnosis of lead poisoning had continued to ingest lead—usually in the form of old-type wall paint—and all had become retarded. Examples were given of children in which lead poisoning had led to death or permanent brain damage.

In describing the length of time needed for treatment and the dangers of reexposure, Dr. J. Julian Chisohn, Jr., of the Baltimore City Hospitals, emphasized the importance of specific measures to protect children from reexposure after the diagnosis has been made.

Other speakers discussed the causes of pica in children, most often found in the low socioeconomic groups.

. . .

Investigations at the National Institute of Arthritis and Metabolic Diseases of the National Institutes of Health have recently pinpointed the cause of Lesch-Nyhan disease, a disorder of childhood associated with the production of excess uric acid and resulting in cerebral palsy, mental retardation, and, eventually, death. Children afflicted with the disease chew away their lips and fingers and seldom live beyond puberty.

The disease has been found to stem from a biochemical defect in the way the body handles purines, the substances from which uric acid is derived. Patients afflicted with it are deficient in an enzyme of purine metabolism, hypoxanthineguanine phosphoribosyltransferase.

The disorder was first described in 1964 by the two physicians whose names it now carries. Since then more than 30 cases, all in young boys, have been reported in the United States, according to records at the Institute. Many cases go unrecognized because the blood levels of uric acid are seldom determined in young children.

Miscellaneous

The U.S. Committee for UNICEF has set up an Information Center on Children's Cultures in its New York City headquarters (331 East 38th St., New York 10016) under the direction of a

librarian experienced in children's literature. The center will provide a mail reference service; issue lists of books about children in other lands; conduct programs for children demonstrating the cultural activities of children in various countries; and give assistance to research workers, teachers, librarians, writers, television producers, publishers, and parents, and others interested in finding and assessing such materials.

. . .

Seven institutions of higher learning are combining their research efforts in early childhood education in a new national program, known as the National Laboratory in Early Childhood Education, supported in part by the U.S. Office of Education, under the Elementary and Secondary Education Act of 1965. The purpose of the "laboratory"—a term used in this instance to denote collaborative association rather than a physical facility—is to coordinate and develop research in this field to improve the education of young children.

The participating institutions are Cornell University, George Peabody College for Teachers (Nashville, Tenn.), New York University, Syracuse University, the University of Arizona, the University of Chicago, and the University of Illinois, which is serving as the coordinator. They will launch new projects as well as work together on projects already under way. Among others, these include or will include inquiries into the educational assets and deficits of Mexican-American children, ways of helping mothers of deprived children assist in their education, the effects of home environment on children from middle and lower economic groups, and the extent of social segregation in nominally integrated classrooms.

Correction

Under the "Films on Child Life" listing in the March-April 1967 issue of *CHILDREN*, Churchill-Wexler Films is erroneously cited as the producer of the films "Boy to Man" and "Girl to Woman" and Henk Newenhouse, as the distributor. The producer of "Girl to Woman" and the distributor of both films is Churchill Films, 662 N. Robertson Blvd., Los Angeles, Calif. 90069. Henk Newenhouse is the Midwest agent for Churchill Films.

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Homemakers as a School Service

Abused Parents of Abused Children

Group Learning for Foster Parents

Louisiana Family Planning Project



children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Schoolmates with a common interest reflect the pleasure of an easy friendship in their smiles. In schools where real integration of the races has long been an accepted practice, color consciousness among young pupils is dim. How vivid it has been in some newly desegregating schools and the ways children have coped with it have been poignantly described by Dr. Robert Coles in a book discussed on pages 197-199.

children

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In Highland Park (Michigan), the public school system has found that the provision of a teaching homemaker service within the school system to help improve conditions in the homes of socially maladjusted pupils has made a big difference in the way such children take advantage of the schools' social and educational opportunities.

For years, the system tried without notable success to cope with the problems of socially maladjusted children in its elementary schools through psychological services, special material in its curriculum, and the use of community agencies such as a child adjustment clinic and a neighborhood service organization. The behavior of maladjusted children, often characterized by aggressive acting-out toward other children and complete lack of respect for adults, was often so great that the children got little or nothing from attending regular classes and so unacceptable that they were excluded from regular classes and sent to special classes. Unfortunately, their parents usually interpreted exclusion as meaning rejection and were unwilling to work with the school in providing treatment for the family. In these instances, the school attempted part-time schooling or referral to the court or to a community treatment agency.

To meet these problems, in 1964 the school system turned over the Lincoln Avenue School to a Pupil Adjustment Project to which all children in elementary school having problems of social adjustment were assigned. The 3-year project, supported by a grant from the Office of Education, U.S. Department of Health, Education, and Welfare, set out to demonstrate that a public school system can provide the psychoeducational services necessary to treat or prevent social maladjustment in children.

Highland Park, a politically independent unit enclosed by the city of Detroit, faces the same problems most inner cities of large urban areas are now facing: it is in social transition and is inhabited by people of several racial, religious, and national backgrounds. For these reasons, it presents conditions that make it nearly ideal as a laboratory in which to examine social and educational problems and to test and demonstrate solutions to them.

Correction and prevention

The project has a two-pronged goal: through *remedial work*, to help the children assigned to the school learn to use educational opportunities effectively; and, through *preventive measures*, to modify

the

TEACHING HOMEMAKER in a school project

MARY E. BURNS • JULIA ANN GOODMAN

patterns of family life that encourage the development of social maladjustment in children.

To achieve this goal, the project drew up a three-part plan. The first part called for a school program using special educational methods, small classes, and individual attention to help the children learn how to benefit from the school socially and educationally. The second part called for social casework and groupwork services for all children at Lincoln and for their families to effect positive relations between the child and the school, the family and the school, and the child as a member of a schoolclass and other children in the class. The third part called for the entire staff of the project, both educational and clinical, to involve all parents, both mothers and fathers, in social and educational activities in the school. These activities were to include special meetings between parents and staff members: parent-teacher conferences in place of report cards; and involving parents, usually in groups, in planning for school activities such as picnics, camping trips, holiday dinner parties, and field trips.

The third part of the plan also included setting up a teaching homemaker service to offer individual parents and parents in groups a program aimed at helping them make their homes adequate and orderly, qualities missing in most of the homes of children assigned to Lincoln, through instruction on homemaking in the home. Lincoln's staff believed that orderly homes would provide children with the kind of orderly model of the world they needed to bring more order into their behavior. The use of a homemaker to instruct a family in homemaking rather than as a mother's helper or substitute was an unusual feature of the project.

The school's homemaking service began in September 1965. Lincoln Avenue School had 83 children from 26 families. Six families were not intact; one mother was dead, five fathers were absent. Four families had acute housing problems; 14 families had insufficient income; 13 families had acute health problems. Both parents worked in 10 families.

The project's staff included three social caseworkers. In addition, a professor of social work at a nearby university served as a permanent consultant to the clinical staff. To recruit homemakers for the program, the school contacted nearby agencies such as the United Community Services of Metropolitan Detroit, which was itself setting up a homemaker service in Detroit; the Merrill-Palmer School, where candidates for the new Detroit homemaker agency were being trained; the local office of the U.S. Employment Service; and local Highland Park agencies, including the department of home economics of Highland Park High School and the local visiting nurse association.

In September 1965, two young women were engaged as teaching homemakers. Both had been married over 10 years and each had two children. One, a native of Detroit, had been a case aide for the Detroit Department of Welfare before moving to Highland Park. The other, from West Virginia, is a home economist. Both had worked for the Co-operative Nursery School Program run by the Highland Park public school system.

At the onset of the program, the staff received help from a consultant, the director of a homemaker service in Washington, D.C., in preparing statements of purpose and policy and in designing the program's structure. At this time the role of the home-

maker was defined as that of a "teaching homemaker" who uses a variety of educational methods. The chief social worker was made responsible for supervising the homemakers and for assigning the cases. The homemakers worked as integral members of an interprofessional team of caseworkers, psychologists, and teachers and their services were a key adjunct to the casework process. The caseworker assigned to the family was responsible for direct work with the family.

Knowing that the homemakers and caseworkers were part of a team calling for unusual relationships and that there were few guidelines to insure effective interaction among team members, the staff met weekly to discuss these aspects of the service:

1. Clarification of the distinct and the overlapping areas of the work of homemakers and caseworkers.
2. Development of ways in which homemakers and caseworkers can work together effectively to carry out casework plans for particular families.
3. Ways to break down socioeconomic and cultural and lay and professional bias that might be reflected in the work of the caseworkers and homemakers.
4. The need for the homemakers to be accepting, flexible, and adaptable and to use imagination and sensitiveness in helping families with their problems.

Kinds of tasks

In reporting on their first days, the teaching homemakers made these comments:

When we were asked to be teaching homemakers, a number of questions came to our minds. What would we wear? Would we be accepted? If not, how could we sell ourselves to our clients? What kinds of problems would we encounter? What should our goals be? We defined our goals as "to gain the confidence of the parent, to help, to teach, and to create an interest in upgrading family life." (An easy task—on paper!)

* * *

It took many weeks of preparation before going into the homes. We read case histories to familiarize ourselves with identifying family data and existing problems and to try to decide what services would be needed. We gathered material on household hints, child care, meal planning, marketing, budgeting, proper cleaning techniques, and recipes which would fit limited food budgets and meet the nutritional requirement of the family.

After 18 months of experience in the use of the educational homemaker program, the staff of Lincoln can now place the activities of the teaching homemaker's job under these three categories:

1. Teaching good methods of home management, child care, and personal care to families individually. Here, the teaching homemaker's task as part of the team is to help set up and maintain equilibrium in the family. (For example, a homemaker helped a mother draw up a budget for her food money.)

2. Helping individual families use medical and health resources to correct and prevent severe family problems and the related problems of children. (For example, in a home where the mother had a severe skin disorder and the children had it intermittently the teaching homemaker got the mother to take steps to prevent the spread of the infection.)

3. Setting up broad group educational programs that allow the homemaker to use her talents and creativity. (For example, the teaching homemakers introduced a program for small groups of mothers to show them how to plan meals, mend clothing, and refinish furniture.)

The teaching homemakers worked a 7-hour day for 5 days a week. Usually each homemaker was in two homes a day for 3 hours each. The other hour was taken up with travel and writing brief reports of activity, including an evaluation of the service and how the homemaker was received in the home. To confine the homemaker as much as possible to teaching, the policy was not to allow the homemaker to stay in any home for a full 7 hours, except in an emergency. Because some families attempted to use the homemaker as "domestic help," the two homemakers visited the same home alternately.

After their first visits to several homes, the homemakers found they needed many supplies. They reported:

... we realized we needed our own cleaning supplies and equipment. Not only was there lack of money in the home for this kind of equipment, but also a lack of knowledge of supplies needed. For our own protection, antiseptic soap headed the list. Many of the homes had no workable laundry equipment; washing machines were either absent or broken; irons outdated or broken. We found we needed two sewing machines a console to be used in the school and a portable to take to homes.

Thereafter, they carried necessary cleaning supplies and equipment in their automobiles to and from each home. Equipment was never left in a home.

The homemakers never gave money. If a family was without food or other essentials, they reported the need to the caseworker assigned to the family.

The teaching homemakers wore distinctive uniforms of blue-and-white striped cambric pinafores

decorated with an emblem reading "Teaching Homemakers Lincoln Avenue School." They also wore long-sleeved navy blue coat sweaters when working in unheated homes.

The first home

No words can tell better than the homemakers' own what the first home they visited was like and the problems it presented:

Going into our first home (a family of six children, mother, and father) and seeing the conditions of the home and the number of problems, we wondered if we had accepted jobs too complicated for our abilities. This home was roach infested. There were mounds of mildewed clothes piled in the basement. The two younger children in the home were hungry and naked; they were both ill with diarrhea. The mother suffered from a severe skin disorder and could not put her hands in water. The house was in complete disorder. In addition to the clothes in the basement, soiled and clean clothes mixed together were piled on the living room sofa, chairs, and floors. Bread, jelly, peanut butter, and dry cereal were strewn on the floor from the front door to the back door.

This family was in a state of nearly complete disorganization. In addition to chaotic conditions in the house, the personal relations between mother and father and between parents and children were both aggressively and passively hostile. The mother never talked to the children except to swear at them and to call them obscene names. She, more than the father, disciplined the children severely. The parents met neither the emotional nor the basic physical needs of the children. Health problems were rampant, but no medical care was ever sought. The father provided income, but no other physical or emotional help for the family. He and the mother had a severe marital problem, and he was absent from the home more than he was present. The mother was almost completely immobilized by her physical and emotional problems.

The children of the family who were referred to our school were markedly withdrawn, could hardly speak except in obscene expletives, and were failing in their schoolwork. Psychological testing at the time of the referral indicated that they had potentially average intelligence but that their ability to function was impaired. Psychiatric evaluation indicated that they were suffering from severe emotional, as well as physical, deprivation and that they were distrustful and fearful of interpersonal relationships and had potential for marked aggressive behavior.

To meet this family's needs required all of our school's services: intensive casework; groupwork; homemaker services; and special educational pro-

grams, including, in addition to special classes, special educational diagnoses and tutoring from our reading specialist. In addition, through our casework service, we called on other community services such as the public health nurse and visiting nurse services, a dermatological clinic, and an adult psychiatric clinic for help. Through our own pediatric service, each child received a complete physical examination.

When the homemaker first entered the home, the mother could not think of what help the homemaker could be. Finally, she asked the homemaker to throw out an open jar of peanut butter, covered with roaches, which had been on the table for weeks. From this beginning, the homemaker moved step by step with the mother to do the laundry and clean the house.

Each week the homemaker gave the mother a little more responsibility for doing tasks in preparation for the homemaker's visit: The first week she was only asked to gather the soiled clothes in one place; but in the weeks following she was asked to also sort them by color and by kind, to run water in the machine, and to put the clothes in without getting her hands wet. Finally, with encouragement, the mother could handle the laundry herself. The husband was induced to mend and put up a line that had been down for several years on which the clothes could be hung to dry.

Casework with the parents was directed at modifying the hostility toward the children; changing the pattern and forms of discipline; and supporting the parents' continually improving ability to act as parents, through the mother's pregnancy and the birth of a seventh child. Homemaker and caseworker often got in touch with each other to share information and diagnostic understanding and to discuss immediate and long-range goals for treatment. They carefully coordinated treatment plans and activities.

After many months of receiving intensive casework service during which both teaching homemakers worked with the family, this family showed marked improvement in many ways—the marital relation-

Mary E. Burns (right), a professor at the University of Michigan School of Social Work, is social work consultant to the clinical staff of the Highland Park public school system's pupil adjustment project reported on here. Julia Ann Goodman, a certified consulting psychologist, serves as the project's clinical coordinator.



ship, child care, home management, and physical and emotional health of the parents and children. The parents even joined in group activities at the school.

The positive influence of this method of working with the whole family was reflected in the children's behavior. They became more spontaneous, talkative, and comfortable with other people. And they began to respond well to remedial education.

The parents' change in attitude toward the school and their acceptance of the school program brought about another important gain. Their positive attitude, which they transferred to their children, greatly increased the children's ability to do good school work.

Problems with other families ranged from simple to complex, from the need of a mother to learn how to prepare appealing and nutritional meals to a father's need for help in finding a housekeeper for his motherless family. In some families the homemakers together gave as many as 156 hours of service; in others, only 8 or 10 were required. Many families continue to need teaching or supportive services.

As the homemakers became more familiar with the families, they found that similar problems existed in several of them. In the belief that the mothers in these families would respond to the group method of treatment, they planned activities for the mothers that resulted in weekly meetings to consider many aspects of homemaking. The homemakers found the group meetings had good results in many cases.

The value of groupwork was particularly noticeable in one family. The mother had received many hours of teaching homemaker service in her home but showed little evidence of changing until she attended a group meeting on refinishing furniture. Through her interest in the work, she changed her run-down house to a bright and pleasant home. In turn, her husband, responding to the change inside the house, repaired and painted the outside.

Part of casework

In reviewing the work of the teaching homemakers, the members of the team see the service as a part of casework service. It is oriented to change; it has specific goals within the caseworkers' goals; and its methods are on-the-spot teaching about and demonstration of effective home- and child-care practices. The effective use of such a service presupposes that these requirements are being met:

1. A diagnostic evaluation of the family and of the role of each member, including an evaluation of each

member's motivation and capacity for improving and a clinical judgment that the parents are not providing adequate homemaking and child care.

2. Based on this evaluation and judgment, a selection of what further services are needed and available.

3. A continuing evaluation of family need and changes in goals and services as required.

Responsibility for diagnosing the family's problems and for deciding whether to use the homemaker as a teacher rested with the caseworker, as set forth in the casework plan. As teachers, the homemakers showed the contribution this kind of service could make to help the Pupil Adjustment Project attain its goals. The nature of the problems presented by the families required the homemakers to assist families in ways besides teaching. In addition to working with parents directly, they had to help make plans for medical care, care for children when a mother could not, stabilize families in a crisis, and relieve overburdened mothers.

As we see it, the success of the teaching homemaker program depended on the following factors

1. From the homemaker, acceptance of the parents to be taught; conviction that parents want to be good parents; skill in working together with parents (doing *with* rather than *for*); ability to demonstrate good homemaking and child-care methods directly and indirectly; and ability to recognize the parents' attainment and to praise them for it.

2. The kind of team relationship that prevents the development of rivalry or dissension between caseworkers and homemakers from overlapping responsibilities.

3. Careful selection of the teaching homemakers

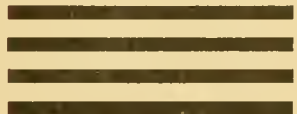
4. Conviction on the part of the entire staff that a teaching homemaker service is worthwhile.

Under these conditions, teaching homemakers provide a treatment resource that can be useful in many instances. They have certainly helped many of the children of Lincoln Avenue School and their parents. The demonstration at Lincoln School of what such a service can do has prompted the Highland Park public school system to provide a homemaker program for its entire school district under a special grant from the State.

understanding
comes first
in helping



the ABUSED parent of the ABUSED child



SIDNEY WASSERMAN

● Willful intent in parents to injure their own children is an “unthinkable thought” for most of us. Even physicians, persons who seem to be in a position to judge whether violence has been done to a child, are often unwilling to accept the “reality of willful child abuse,” according to a recent survey among physicians in the Washington metropolitan area conducted by a group of psychiatrists.¹ A fifth of the nearly 200 physicians questioned said they rarely or never considered the “battered child syndrome” when seeing an injured child, and a fourth said they would not report a suspected case even if protected by law against legal action by the parents. Apparently, they did not believe the evidence would stand up in court.

To accept as fact that some parents intentionally injure their children is difficult and upsetting. Thus, we all tend, like the physicians studied, to give the parent “the benefit of the doubt.” There may be many reasons for our reluctance, but one is certainly this—when we accept willful intent as a fact, we must face our anger at such parents and our desire to protect the child, even if we harm the parent. But we cannot effectively intervene to protect an abused child and prevent abuse from recurring unless we understand what it is like to be a “battering parent.”

One of the dangers of using the label “battering parent” is the possibility of increasing bias and prejudice against the parent. Labeling a particular person as a “battering parent” can release us from the responsibility of making our response to and attitude toward his actions sensitive to his needs. The

temptation is great to think of him as being far removed from those of us who do not batter our children. In so thinking, we keep intact our image of ourselves as righteous.

How easy it is to deny that within all of us lies a potential for violence and that any of us could be unreachable! What is more repugnant to our rational, “mature” minds than the thought of committing impulsive, violent acts against a helpless child? We tell ourselves that the primitive, untempered instincts responsible for such acts could not erupt in us. But stripped of our defenses against such instincts and placed in a social and psychological climate conducive to violent behavior, any of us could do the “unthinkable.” This thought should humble us: perhaps we are not battering parents only because conditions do not lead us to commit “unnatural” acts.

No class monopoly

Writers on social phenomenon, lawyers, social scientists, and others interested in social problems have long recognized that the phenomenon of parents physically abusing their children has been with us since the beginnings of mankind. Only since World War II, however, has much been written on the subject of unexplained, shocking, and traumatic injuries to children. Since then, too, much has been said and written about the legal confusion surrounding the use of authority and sanctions in instances of apparent abuse of children by their parents.

Historically, the helping professions have viewed physical abuse of children by their parents as the result of poverty, life in the slums, ignorance, and the hardships produced by immigration, war, industrialization, and urbanization. No one can deny that these conditions can be a cause of child abuse. Nevertheless, we are finding that the phenomenon can be found anywhere in society. Once we regarded violence against a child as characteristic of parents in the lower socioeconomic classes. Now we are finding that such behavior is not exclusive with any particular social class but that "better" families can more easily conceal the problem than poor ones. In other words, a sociological explanation by itself is inadequate and simplistic.

Through sometimes frustrating and bitter experience, the professions, and particularly that of social work, have come to see that prosecuting the battering parent solves the problems of neither the child nor the parent. Helping the abused child leads us inevitably to the need to help the battering parent and family. As pointed out by Delsordo,² Boardman,³ Nurse,⁴ and others in studies of child abuse, practically all cases of abuse involve longstanding, severe interpersonal conflict either between the parents themselves or between one parent and another member of the family.

Because we are dealing with a complex subject involving many social, psychological, medical, and legal elements, we must narrow our scope and take first things first. Nothing precedes understanding who the battering parent is and what he is. Studies point out that battering parents and families, regardless of class, have certain psychological and social characteristics in common; for example, we are learning more all the time about the severe damage to personality these people suffer. Few are psychotic, but all have marked inability to set up a genuine relationship with another human being. Absorbed by their own hurt feelings, they cannot sympathize with the feelings of others. The nonpsychotic batter-

ing parent seldom shows remorse for having hurt his child, but he can be very much concerned about the harm a person in authority might inflict on his own person. When facing a person in authority, he cries out: "What are you going to do to me?"

"Done to"

Obviously, something went haywire or was not touched in the humanization process when such persons were growing up. Apparently, they never had the kind of relations with other people that offers incentives for delaying pleasure or gratification or the feeling that it is worthwhile to yield an immediate, antisocial pleasure for the love and acceptance of another. They have been "done to" both socially and psychologically. A battering adult goes about his daily life with the gnawing, unfulfilled feeling of having been unloved or not having been loved as much as he should have been as a child. His life is focused on his own needs, and he cannot tolerate any frustration to the gratification of those needs. What else can he feel but his own hurt, his own hunger for love? He is anesthetized against feeling compassion for others.

This kind of person, according to Reiner and Kaufman,⁵ is unaware that he has a buried feeling of "imbedded depression" because he was emotionally or psychologically abandoned by his parent as a child, an act he interpreted as rejection of himself. Unable to understand such a distressing emotional event and not psychologically strong enough to bear it, as a child he buried the feeling of rejection deep within himself and with it the accompanying depression. Because his use of language was not developed, he expressed his feelings by the only means he had—his behavior. Explosive, violent behavior became his means of communicating with those around him. When he was violent, he was unable to feel his hurt, his sense of worthlessness, his depression. Denied a consistent, supportive relationship with an adult, he set up a life pattern of aggression and violence—and is now inflicting on others what was inflicted on him. For him the world is hostile and dangerous: it is a place where one attacks or is attacked.

Studies also suggest that the battering parent feels his parents were punishing him when they rejected him and that he is longing for a mother. He wants to be loved, yet does everything to prevent another from loving him. Instead, he is caught in a cycle of violence and rejection. When speaking of his physical attacks on his child, the battering parent strongly

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defends his right to act as he has. He seems unable to feel love for and protectiveness toward his child. He can be extremely compulsive in his behavior and make unreasonable demands on his child. Cleanliness, for instance, may be an obsession with some. I have heard of a child being mercilessly beaten for putting chicken bones on a clean tablecloth and of an 18-month-old baby being seated with his buttocks uncovered on a hotplate whenever he soiled himself. Such people are way over their heads when they become parents. How can they give a child what they have never had themselves—security, safety, and love?

The hostility sponge

This description is supported by a growing amount of evidence that when a battering parent becomes violent, he apparently is releasing his rage on a particular child, selected to act as the "hostility sponge" for that rage. The parent views the child as a competitor, as someone taking and getting what belongs to him. The child is an unconscious symbol of someone or something that once caused him pain—a competitive brother or sister, a distrusted parent, his rejected self. Sometimes the parent is reliving a childhood experience that left him traumatized. Some of these parents talk about being rejected by their own parents in favor of a brother or sister.

In many instances the abused child has been conceived out of wedlock. The parent is now punishing him for being the cause of an unwanted marriage. Sometimes a stepfather is the offender. He beats the child for reminding him of his wife's "badness." Or the mother may beat the child because he reminds her of her "badness" or of that "bad" man, his father, who deserted her when she was pregnant. By beating out the "badness" in the child, the parent beats out his own badness or that of another person who has injured him. In other words, the parent is reacting to his own inner feelings, not to the behavior of the child. The child is the provoker by being what he is—an infant or a child demanding attention. It is this demand that provokes the parent.

The use of the child as a hostility sponge may be absolutely essential to the mental balance of the parent, and, thus, the child is sacrificed to that mental balance. Removing the child from the home without a well thought-out plan to help the parent and the family may only invite the parent to shift his rage to another child. We can easily get caught up in symptom-shifting without getting to the bottom of

the problem—the parent's need to be protected from himself.

To really help such a parent, we must break the chains he has inherited. To do that, we must clearly understand that intervention should act as a brake on the parent's behavior and that the injuries he inflicts on the child, injuries that bring the attention of the community to join them, are his way of saying—"Stop me!" The act of rushing a child to a hospital or of beating him in front of neighbors or strangers carries a message to the community—"Please save me from going out of control. Stop me from going out of my mind. Keep me from—killing!"

We are gradually realizing that in such cases we are dealing not only with a seriously disturbed person but also with a disturbed family. Once the existence of abuse is ascertained and the degree of imminent danger determined, the parent and the family must be dealt with whether or not the child is removed from the home. Even in cases where law enforcement has been effective and community services have been well coordinated, problems in helping the battering parent and the family remain.

According to Zalba,⁶ battering parents tend to deny their actions, the husband or wife of the battering parent protects the other, or the children are too young to explain to outsiders what has occurred in the home. The parents also tend to deny the existence of personal or family problems and to provoke judges, lawyers, and social workers by making impossible demands on them; or they rage at everyone in authority and, sometimes, physically attack them.

Firmness above all

In reaching out to the battering parent, we must keep in mind an important key to his behavior—his fear of a close relationship. Because he suffered rejection in early life, he wards off human relationships.⁵ He has emotionally divorced himself from the significant people in his life. He feels safer with and responds more readily to a relationship that clearly offers authority—firm but not punitive. In other words, the battering parent can often be reached by setting firm limits and controls on his behavior. Whatever he may say, he needs firm control—and wants it. In the early stages of trying to reach the battering parent and family, the social caseworker or other helper must make realistic judgments and decisions for and with the parents and family to gradually help them develop a sense of reality.

To provide this basic treatment requires long-term help from a consistent relationship with one person only. Shifting the parent from one worker to another only stirs up his basic, deep-seated belief that to get close to another human being is to expose one's self to hurt and abandonment. Deep within, he sees himself as the kiss of death in personal relations. He wants to get close to another person, but he thinks that if he does the person will learn to dislike him and will break off the relationship. For a long, indefinite period, the helping person must stand by and support the parent by setting limits and by providing services through community resources. He must not try to get too close to or expect such a person to unload his innermost feelings, especially feelings he is hardly aware of. For such a person, having limits set on explosive, violent behavior provides the kind of protection a good parent would give. The battering parent must be constantly assured that he will not be allowed to get out of control. At the same time, he must be assured that the worker believes that he does not want to hurt his child, that he is capable of change, and that he wants to be a better parent. He needs to learn what the community expects of him and what choices he has. He needs to be helped to understand clearly that consequences will follow his violent act and what those consequences will be.

A long process

In this long and trying process, such a parent will continually test the patience of the helping person and will use every means to provoke rejection to reassure himself that he will not be rejected. For a long time he will reveal only his unlikeable side. When he is reassured, he will make feeble attempts to plant the seeds of a relationship. Reaching out to such a person makes a very great emotional and intellectual demand on the helping person. The battering parent is very perceptive and can immediately sense insincerity. Actually, the helping person must become the "hostility sponge" instead of the child by letting the parent test him, yet he must never let the parent get out of control.

Psychiatrists, psychologists, social caseworkers, and other persons trained for this work have observed that as treatment progresses and a basic trust is established the battering parent gradually faces up to the depression within himself. With extreme caution, he talks about his deep-seated fear that he is a loser and that people always desert him. Only

when his need for violence abandons him and he stops expressing himself through it can he talk about his childhood and begin to come to grips with his problems. Though he improves, he continues to try to provoke the helping person, for he is never convinced that he will not be rejected. However, he does move cautiously toward having a relationship with the helping person, gives up or modifies his violent outbursts, and lets himself be guided toward patterning his actions after the standards of the helping person. In time, the pattern becomes a part of him and a new self appears.

To start and set in motion such a long, painstaking process requires a firm commitment by the community to providing excellent service, a goal not easily attained. To obtain qualified staff members and to train persons specifically as workers are expensive and time-consuming. Often efforts to reach the battering parent are obstructed because workers—nurses, social workers, volunteers—come and go frequently on the staffs of agencies. For the battering parent is likely to regard a change in workers as another experience in rejection. The helping person may leave the staff at the most critical moment—just as the parent is testing the worker to find out if rejection will follow his actions. The parent takes the worker's leaving the agency as proof that it never pays to get close to another person. If only a community or agency could insure permanent service for such troubled human beings!

But life affords few opportunities for permanency. We are all only temporary to each other. That is a human condition, and most people accept it. The battering parent cannot. Plans for helping him must include ways to help him accept this truth. We must be ready to test various methods of working with him, always keeping in mind his deep fear of involvement and loss. We must continue to direct efforts to alert the medical, legal, and social work professions, and all groups who might come in contact with the battering person to the need for continuity in helping him. The challenge is not a small one; social workers are finding that cases involving battering parents as well as other hard-to-reach families are making up more and more of their caseloads.

In addition to individual treatment, working with groups of battering parents and their spouses is also proving effective. Many of these parents are isolated from the community. Having an opportunity to socialize in a group of similarly troubled parents tends to lower their resistance to facing and discuss-

ing their problems.⁶ Working with such families as family groups has also proved effective.⁶

The community must learn

Beyond the abused child, his parents, and his family is the community around them. Battering parents and their families suffer from a not uncommon malaise often called "community exclusion." In various ways, whether economically, politically, psychologically, or socially, these families frequently suffer exclusion. Unfortunately, when such persons vent their rage on their children and the shocked community retaliates immediately, the family's sense of rejection is increased. A cycle of reciprocal aggression is set in motion and, once set in motion, is difficult to halt. The battering parent often succeeds in provoking hospitals, the police, the courts, and social agencies into treating him as his parents once treated him—the opposite of what he needs. Communities must constantly reexamine ways to set up controls and limits while bringing all families into the community life. When a battering parent has only known "community exclusion," he desperately needs "inclusion" to break the cycle.

Finally, we cannot examine our attitude as a community toward the battering parent without examining what it means to be part of a whole—a State, a nation, or the world. Like it or not, we are bound each to the other and our destinies are interwoven. As we try to understand the battering parent, we must look into ourselves to find out what there is in each of us, in our community, our Nation, and the world that the battering parent takes as a sign that what he is doing is permissible.

To answer this question we must face up to the

paradoxes in our moral code that condemn violence in one form, permit it in another. Many Americans seem to persistently dismiss from their thoughts and acts a basic truth—there is nothing more precious than human life, or so it seems to me.

The people of the United States have yet to learn how to convert their tendency to violence into compassion and tenderness. We are in danger of losing sight of one of this Nation's major social goals, one on which it was founded, that is, to tap the humanity and creative potential of all citizens and to provide the environment and resources necessary for the individual citizen to realize his creative potential. We possess the potential both for violence and for humaneness, and are capable of acting in brotherhood and with understanding. If this were not so, we would not now be seeking new and different ways of helping our less fortunate citizens. By seeking to tap the humanity and potential for growth of the battering parent and family, we are tapping our own potential for personal, community, national, and international growth. We must ever encourage the tapping of this potential.

¹ Silver, L. B.; Barton, W.; Dublin, C. C.: Child abuse laws—are they enough? *The Journal of the American Medical Association*, January 9, 1967.

² Delsordo, J. D.: Protective casework for abused children. *Children*, November–December 1963.

³ Boardman, H. E.: A project to rescue children from inflicted injuries. *Social Work*, January 1962.

⁴ Nurse, S. M.: Familial patterns of parents who abuse their children. *Smith College Studies in Social Work*, October 1964.

⁵ Reiner, B. S.; Kaufman, I.: Character disorders in parents of delinquents. Family Service Association of America, New York, 1959.

⁶ Zalba, S. R.: The abused child: II. A typology for classification and treatment. *Social Work*, January 1967.

The hardest work in the world is being out of work. There is nothing more difficult or tragic than for a father to return home night after night after an unsuccessful day hunting for a job—a job requiring skills which he does not possess. There is nothing harder than sending one's children to school on an empty stomach. There is nothing harder than living in a slum, than fighting the rats, than pleading with the landlord for heat, than freezing in winter, or than sweltering in summer.

Whitney M. Young, Jr., Executive Director, National Urban League, to the 1965 forum of the National Conference on Social Welfare.

GROUP LEARNING FOR FOSTER PARENTS



I. IN A VOLUNTARY AGENCY

HARRIET GOLDSTEIN

Over the past 7 years the foster parents who care for children placed with them by the Association for Jewish Children, a voluntary agency in Philadelphia, have helped the agency develop a broad program of group activities designed to improve their competence as foster parents and enhance their status within the agency. The program has not only contributed to the foster parents' confidence in their ability to cope with the children in their care but also to the professional workers' understanding of the problems and feelings of foster parents and, hence, their skill in working with them.

At any one time, the agency has about 100 children—most of them severely emotionally disturbed—in the care of 70 to 75 couples whose homes have been approved for foster care.

While the agency had long operated on the principle that work with foster parents requires the use of both casework and groupwork methods, until 1960 its efforts to work with foster parents in groups were sporadic and brief. By the end of 1959, its group program for foster parents had been reduced to two events: an annual meeting for them at the agency and an annual party given in their honor by the board of directors. However, because of its previous experience and the many expressions of interest from foster parents in having opportunities to come together more often, the agency never lost its conviction that a broader, more dynamic group program for foster parents was desirable.

Early in 1960 the agency took steps to get the foster parents' own ideas on the subject. It submitted

a questionnaire to all its foster parents, seeking their frank opinion about (1) whether they wanted a group activities program; (2) whether they would be willing to help the agency develop a new program; (3) what suggestions they had for its form and content; and (4) what they thought were the reasons why the former group programs had not been sustained.

Eighty percent of the foster parents responded to the questionnaire, most of them indicating a strong interest in participating in an expanded group program.

Getting under way

The agency was determined not to produce another short-lived group program. It, therefore, re-examined its previous experience with group programs in the light of the foster parents' responses to the questionnaire and identified 10 major points that would have to be kept in focus in developing and operating an expanded group program.

These points were:

1. Staff members have to be available to the foster parent groups on a sustained basis.
2. The staff members have to be flexible enough about their working time to participate in evening meetings or Sunday events.
3. Agency suggestions about programing cannot be imposed on the foster parents but can only be introduced as the foster parents are ready for them.

4. Out of respect for their "quasi-professional" status, the foster parents must be encouraged to assume responsibility for planning and handling their meetings.

5. To function adequately as "quasi-professional" persons, the foster parents need to have a complete picture of the agency's operations and some knowledge of the other child welfare programs in the community.

6. Because foster-parenting is a specialty for which formal training has not been developed, one goal of a group program must be to teach the participants how to fulfill better their role as foster parents.

7. Participation in a group program can help foster parents who have few opportunities for socialization compensate for this deficiency by giving them a closer identification with the agency and the broader community of child welfare services than they had when they became foster parents.

8. Through participating in programs with other couples who are caring for foster children, foster parents—who often feel isolated in their work with children—can come to see the problems of foster children and their natural parents in a broader perspective.

9. All foster parents cannot be expected to participate in the group activities, but in order not to cause confusion for those who do, communication needs to be kept open between the caseworker in charge of the group activities and the caseworkers who work individually with the foster parents.

10. The principle of confidentiality of information must be respected in regard to children and foster parents, although in group activities the foster parents will inevitably come to know a good deal about each other.

To involve the foster parents in planning the group program, the agency called a meeting of eight couples who had expressed an interest in participating in such planning. At the meeting, the group was officially designated as the Foster Parents Planning Board. This board, now expanded to include 12 couples, still contains five of the original eight. Over the years it has worked with the staff in developing and coordinating the educational and social activities in a greatly expanded program for foster parents. Step by step, the program has grown until

today it includes an annual institute, monthly discussion groups, an annual series of study workshops, and a variety of informational and social activities.

Experience in learning

The annual foster parents' institute was the first project planned. The first institute was held in October 1960; the eighth will be held in September 1967. The institute is always held on a Sunday evening and is attended by foster parents, staff, and board members. The foster mothers take complete responsibility for preparing a dinner for the entire group. In doing so, they have learned to work well together.

Following the dinner, a topic for discussion is presented through a film showing or a production of one of the Plays for Living, or by a speaker. After the feature presentation, small groups led by staff members and foster parents provide opportunities to discuss the points made. Subjects selected for the institutes have been: (1) The "Normal" Needs of Children; (2) The Foster Parent, Caseworker, and Community; (3) The Placed Child; (4) The Religious Life of the Child in Placement; (5) Handling the Adolescent; (6) The Unmarried Mother in Today's Society; (7) The Deep Well—Life in Foster Care; and (8) The Educational Deficits in the Placed Child.

In developing the format for these institutes, the agency considered the following points: This type of meeting might satisfy the needs of those foster parents who wanted some agency connection and some opportunity to learn more about the principles of caring for foster children, but who did not necessarily wish to attend a series of meetings. It might whet the appetite of other foster parents for more programs of an educational nature. It might break down some of the barriers between foster parents, caseworkers, and the agency's board and contribute to a cross-fertilization of ideas among them. It might help fill the social void in the lives of some of the foster parents and help them develop an esprit de corps. It might give the members of the Foster Parents Planning Board a sense of accomplishment.

Subsequent experience indicates that this annual event achieves a measure of all these goals.

Stimulated by the first institute to want more group activities, the Foster Parents Planning Board asked for a series of discussion meetings open to all foster parents focused on foster family life education, and followed by a coffee hour. Such meetings, initiated in 1961, are now held every month for 6

months of the year. Held in the evening, they are attended regularly by about a third of the parents.

At first, these discussion meetings centered almost entirely on two topics, the agency in general and the natural parents of children in care, both topics emotionally charged for the foster parents. In the early sessions, they revealed a lack of knowledge about the agency, its staff, and its place in the community's social welfare structure. In discussing the natural parents of children in foster care, most of what the foster parents had to say was negative and hostile.

As time went on, the foster parents who attended these meetings developed a deepening appreciation of their place in the agency's constellation of services. They also began to examine more realistically the source of their hostility toward the children's parents and to show an increasing awareness of how their negative attitude tended to loosen the children's ties to their parents and to themselves. They also gradually became interested in learning more about the "why" of children's and adults' behavior, including their own.

Over the years, the foster parents have revealed in their group discussions an increasing thirst for knowledge about the origin of behavior and a desire to identify themselves more closely with the agency. In these meetings, they have learned much about the structure of the agency and its services from members of the agency's staff, including the casework supervisor who conducted the meetings, the agency's administrator, the psychologist, the psychiatrist, and the tutor; and about the dynamics of children's behavior and ways of handling behavior problems from other professional persons in the Philadelphia area, as well as from members of the agency's staff.

The workshop series

In 1965, some of the foster parents expressed an interest in having an opportunity for a deeper learning experience. They were backed by the Foster Parents Planning Board, which pointed out that most of the foster parents had never participated in the kind of planned educational program professionals are used to. Plans for an experimental workshop series ensued. This was designed to cover eight 1½-hour sessions centering on an analysis and discussion of case material, under the leadership of a caseworker, at the end of which each foster parent would turn in a written report. It was decided to restrict participation in the workshop to 10 couples who were caring

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for preschool or school-age children and to select those who were the first to apply after the series was announced.

As a topic for the series, the planning board chose "The World of Foster Care" as one broad enough to give the leader leeway in the presentation of material and to provide many stimuli for discussion.

Four more couples applied for the workshop than could be accommodated. Of the 10 couples selected six had been foster parents from 8 to 13 years. Seven couples attended regularly; three had to drop out because of unforeseen circumstances that arose in their families.

The case material centered on a 5-year-old foster child, Jimmy. Before each session the participating foster parents were sent portions of the case to read and were asked to consider certain aspects. They also received a summary of the previous session, prepared by the leader.

The discussion focused on the following aspects of the case:

1. *The child*: his behavior patterns before and during placement; the possible meaning of this behavior; the "normal" behavior pattern of a 5-year-old child and what constitutes deviant behavior; the developmental tasks of children from ages 1 to 5; the modes of expression used by a child to release fears and anxieties—his grief and "mourning" following placement and his demands on the foster parents during this period; a child's feeling of guilt because he created the problem necessitating the placement.

2. *The natural parents*: the background and history of Jimmy's parents; the cause and effect of the interaction between his parents; parental attitudes affecting Jimmy's development; the meaning to parents and child of the parents' impaired capability for being parenting.

3. *The foster parents*: examination of the attitude of Jimmy's foster parents toward his own parents

and their reasons for becoming foster parents; discussion of the possibilities and limits in foster parenthood as a way of continuing to have the satisfaction of being a parent; discussion of what foster parents expect of a foster child.

4. *The caseworker:* the role of the social worker in the child's experience before and during placement; the significance of the social worker to the child, the natural parents, and the foster parents.

As anticipated, in the discussion most of the participants' understanding, sympathy, and compassion went to Jimmy. Afterward, the foster parents cited this part of the workshop as being especially helpful as a "baseline" for dealing with their foster children. As one pointed out, "We tend to forget all that we go through in growing up."

In the sessions on the natural parents, the foster parents exhibited surprisingly little anger toward the parents of foster children and a great deal of empathy with them as people. Perhaps this empathy developed in part as a result of their previous discussions in the monthly group meetings. Perhaps it was not impeded by feelings of hostility because the parents being discussed were not those with whom any of the foster parents in the group had to deal. Perhaps it also came from learning about the experiences these parents had endured and recognizing in them elements of their own life experiences.

On the whole, the workshop participants revised their attitude toward the caseworker during the dis-

cussion of Jimmy's case, although they continued to express lingering fear that the caseworker's closeness to Jimmy could impair his relationship to his foster parents. They frequently observed that the caseworker was the connecting link between all parties in the case and that her work was especially important in the preplacement period—a new idea for two of the foster parents who had once been used chiefly for emergency placements. They also observed that the positive relationship that evolved between the caseworker and Jimmy, a highly mistrustful child, was a first step in developing his capacity to relate to adults at all.

The greatest struggle that took place in the workshop revolved around the foster parents' ideas about themselves and their reasons for becoming foster parents—the question of whether they did so to "do good" to another person or to achieve self-fulfillment. In trying to face the question squarely, they talked about the way foster parents seek to avoid hurt by not allowing themselves to love the foster child completely lest the child be returned home, and about their pain at being frequently reminded that the child is not really their own.

This first series of workshops underscored the importance to both the participating foster parents and the agency staff of continuing efforts to develop the skill and understanding of the foster parents. The foster parents found that the series had helped them to bring out and deal with their anxieties as foster parents. The minutes of each workshop session, prepared by the leaders and shared with the foster

Foster parents meet at the office of the Association for Jewish Children, Philadelphia, to discuss their problems in foster care.



parents and their individual caseworkers, deepened the caseworkers' insight into the motivations of foster parents and hence increased their ability to build positive relationships with them.

At the foster parents' request, workshop series were again held in 1966 and 1967 with the respective topics, "The Home Study," and "Children's Behavior Formation and Common Causes for Misbehavior."

In the 1966 series, again led by an agency caseworker, the discussion centered on the record of an actual foster-home study and emphasized the many factors and interrelationships involved in the evaluation of a foster home, an analysis of the matching process, and the weighing of positive and negative qualities in a family in determining whether and how their home will be used by the agency. The participants in this series underscored their need for agency support in dealing with a difficult child and showed increasing appreciation of the similarities and differences between caring for foster children and one's own children.

The 1967 series, led by a psychiatrist, focused on normal and abnormal child development, the parental role in the creation of aberrant behavior, the deviations in behavior to be expected of children separated from their parents for any reason, what can be expected of children placed in foster care, and ways of dealing with difficult behavior in such children. So many foster parents expressed interest in participating in this workshop that the enrollment limit was extended from the usual 10 to 15 couples.

Other activities

In addition to the educational program, the agency, with the help of the Foster Parents Planning Board, has developed a number of other activities designed to bring the foster parents closer to the agency and to each other. These include:

Welcome teas, held intermittently to introduce new foster parents to the activities for foster parents, are organized by a committee of foster parents. As soon as the agency has approved a couple's home as a foster home, the foster parent who heads this committee sends the couple a note of welcome, following it shortly afterward with an invitation to a tea.

A newsletter, issued every 3 months to keep foster parents informed about the agency, the foster

parents' activities, and community programs connected with child welfare. It is written by the agency's public relations director with the help of an advisory editorial committee of foster parents.

A manual for foster parents, developed at the suggestion of the Foster Parents Planning Board, describing the principles and procedures of foster care. A committee of foster parents met regularly with a member of the staff for 18 months during 1965-66 to write the manual.

A transportation committee, composed of foster parents, arranged transportation to activities for foster parents for those who otherwise could not attend.

In conclusion

No formal evaluation has been made of this program of group activities for foster parents. However, the agency is convinced that it has strengthened the foster parents' identification with the goals of the agency—particularly among the 44 couples (approximately 60 percent) who have consistently participated in some part of the educational program. The agency is also convinced that the placements of several deeply troubled children have been sustained through the support and understanding their foster parents have gained through the program and the hazards of replacement thereby avoided. Many foster parents have said that they feel better equipped to cope with their foster children and more certain of their ability to carry out the role of a foster parent because of their participation in the program.

As the foster parents have experienced recognition as quasi-professionals, they have broadened their interest in the welfare of children in general. Some of them, at their own suggestion and with the approval of the agency's board of directors, conduct a yearly campaign called the Donor Fund Project to raise money for the agency's scholarship fund. Others are working with civic groups in behalf of children, writing to legislators to secure better public programs, including better standards for public assistance. Bringing the foster parents closer to the agency has increased their awareness of the complexity of personal, interpersonal, and social problems behind a child's need for placement away from home.

GROUP LEARNING FOR FOSTER PARENTS



II. IN A PUBLIC AGENCY

ADOLIN G. DALL

Five years ago, the Bureau of Child Welfare, New York City Department of Social Services, faced with a loss of foster parents, began a program which, though small, has demonstrated the possibility of helping discouraged foster parents through group discussions to renew their confidence in their ability to handle difficult behavior. Among the foster parents who have participated with intense interest have been several who had become strongly resistant to help from the supervising caseworker.

The bureau established the Division of Foster Home Care 18 years ago to make direct, long-term placements of children needing care away from home. Until then, all such placements in New York City had been made by voluntary agencies under a purchase-of-care arrangement with the bureau, but these agencies had been unable to meet the needs of many children, particularly Negro Protestant children. Because most of the children placed by the division in its early years were infants or toddlers, many of them are still in foster care. Therefore, many of the 1,200 young people in the division's care today are adolescents.

Over the years, the rapid turnover of social workers on the agency's staff, the lack of professional training and experience of the new caseworkers, and the growing number of adolescents in care combined to make many of the foster parents resistant to working with the caseworkers in their behalf. An increasing number of foster parents, especially those with teenage foster children, began to doubt their ability to continue to care for their foster children. Some

discontinued care, thus requiring the agency to replace the children. These foster parents were mature, dedicated people, but they were overwhelmed by the difficulties of dealing with the erratic behavior of adolescents—behavior aggravated in many instances by early childhood deprivations and by the racial unrest in the neighborhoods where many of the foster parents lived.

Therefore, in 1962, the foster care division initiated a series of group discussions with selected foster parents, using as group leaders two members of its supervisory staff, both professionally trained social caseworkers. With the help of inservice training and consultation from a faculty member of the Columbia University School of Social Work, these caseworkers have met regularly for periods of 6 weeks with groups of foster parents, usually in the communities where the foster parents live. Thus far, only 45 of the agency's 550 foster parents have participated in the group discussions, but these have included some of the agency's most discouraged and frustrated foster parents.

From the beginning of the program, the group leaders have kept the caseworkers who deal individually with the foster parents informed of their plans and of the groups' progress. No foster parents have been invited to participate in the groups without preliminary discussion between the group leaders and the foster parents' caseworkers.

At first some of the caseworkers expressed fears about what group participation might do to the individual relationship they had built up with the foster parents, but these fears obviously diminished as the group sessions proceeded. The group leaders have always been available to the caseworkers for individual conferences about particular case problems

Based on a paper presented at the 1967 Forum of the National Conference on Social Welfare.

that have come to light during group discussions.

A brief description of the Center Village Group will illustrate both the objectives and the effectiveness of this group discussion program.

The group

The Center Village Group consisted of 14 foster mothers and two foster fathers whom the caseworkers had had difficulty "reaching." All resided outside the city, far from the agency's office. They were primarily of low-middle socioeconomic status. Twelve were Negroes and four (two couples) were Caucasians. Nearly all had been foster parents for many years, and many of their foster children were teenagers.

Some of the group leader's goals were:

- To give the foster parents an opportunity to express and work out their anxiety about foster care.
- To give the members an opportunity to gain support from the experience of finding that other foster parents had problems similar to their own.
- To heighten the foster parents' identification with the agency.
- To improve the care provided the foster children by increasing the foster parents' skill in child rearing.
- To increase the foster parents' sense of self-worth and so to enable them to accept their foster children more fully.
- To strengthen and supplement the caseworker's efforts to help the foster parents with their child-rearing problems.

At the first meeting, the leader told the group members that they would be meeting for six sessions at 2-week intervals to work together on their child-care problems. She pointed out that the meetings belonged to the foster parents and that all discussion would be based on what they felt was important. From the beginning of the discussion, the foster parents recognized that they had difficulties in common. The following is a condensed excerpt from a report of their first meeting:

The group members talked for a while about how difficult it was for them to tell their foster children about their real parents. Then Mr. T spoke up. His voice was calm when he started, but as he proceeded it became choked with emotion. He said that he was a stepchild, but as a child he had not been

told of this. Until he was 13 years old, he thought that his stepmother was his real mother. Then a distant relative had told him that his real mother was not only still living, but was living in his own neighborhood.

Describing the pain of this sudden discovery, Mr. T said he would never want this to happen to his foster children. There was a hushed silence in the room; but the expressions on the faces of the foster parents showed that Mr. T had the members' sympathetic understanding. The leader supported Mr. T by saying that being told about this experience had helped the group members to comprehend more fully what a foster child may have to face if he does not understand who he really is.

At subsequent meetings the group members helped each other with their common problems in child care in many ways. They also helped the agency learn more about what foster parents were up against and as a result brought about some changes in agency policy. For example, at the fourth group session, they decided to petition the agency to increase its clothing grant.

A foster mother spoke of the inadequacies of the clothing grant. She said her 10½-year-old foster daughter wears very large sizes . . . yet the money the agency gives her for clothing is computed on the basis of the child's age rather than her size. Then nearly all the group members complained that clothing their foster children properly was a real problem for them. One said, "If you buy cheap clothing, it does not wear." Another pointed out that older children have to have a "say so" in the selection of their clothes or they just won't wear them. One foster mother said angrily: "It is impossible—the clothing allowance must have been figured out 15 years ago." Another said that the problem was that "the agency expects you to buy at inexpensive chain stores, and those cheap things will not last. It's throwing the money out."

Pointing out that all of the group members seemed to have the same problem, the leader asked, "What have you done about it?" One foster mother responded bitterly, "We tell our caseworkers."

Mrs. A, the most hostile group member, said that her caseworker just tells her if she spends more money than she should, she can take it out of the next clothing check. She pointed out that this was no solution, since it would only shorten the amount of the next check, and she added, "It just doesn't work out. I have to use my own money."

The leader asked, "What do you think you might do about it?" A group member answered helplessly, "What can we do?" Then one foster mother asked hesitantly, "Could we send a petition to the director?"

The rest of the meeting was spent in drawing up the petition. The agency had been considering increasing the foster children's clothing allowance, but the foster parents' petition undoubtedly helped hasten the process.

As the meetings of the Center Village Group progressed, the themes introduced by the foster parents included the meaning of the foster child's therapy

to the foster family and the foster child, the problem of frequent changes in caseworkers, the trauma experienced by the foster children and foster parents when separation takes place, and the problems of adolescence. The group members expressed their opinions and feelings candidly. Most of them began to see how frustrated they felt when they failed to meet the needs of their foster children.

The leader learned not to get ahead of the group, but rather to help the members to delve more deeply into each "theme" or problem introduced into the discussion. When appropriate, she confronted a group member with the meaning of what he had said or supported an emotionally overwrought foster parent, but, for the most part, she concentrated on helping the group members help each other. Periods of silence became less threatening to the leader as she came to realize that much of what happened at a group meeting was not verbal, that facial expressions, gestures, and withdrawal were all revealing signs of the degree of a person's progress.

In conclusion

Because of the great variety of circumstances and events that can affect what happens in foster care, evaluating the overall effects on the welfare of children of a group program for foster parents is difficult, if not impossible. However, we have found that well-conducted group discussions can sustain the interest of foster parents, for the attendance record in three of our four series has been excellent. Moreover, caseworkers have noted improvements in their relationships with some foster parents after they have attended the group meetings.

Our observations lead us to believe that—

1. Foster parents who felt threatened by their neighbors' negative attitude toward foster care have gained a feeling of support from identifying with each other as members of a group.

2. Foster parents who have been hostile and diffi-

cult to work with in a one-to-one relationship have been willing to discuss their problems of child management with other foster parents.

3. In general, the participating foster parents have gained perspective on their foster-care problems through learning about the problems of other foster parents.

4. The foster parents have often worked out ways together of handling the typical behavior problems of childhood and adolescence.

5. Some of the participating foster parents have formed friendships with each other that have led to friendships between their foster children.

The learning has not all been on the side of the foster parents, for through this experience the agency has increased its understanding of the needs of foster parents and ways of dealing with them. For example:

1. Certain aspects of foster care stood out as problems with which even foster parents of long-standing need continuing help—especially the foster child's need to achieve a clear conception of his identity and the foster parents' fears about losing the child.

2. Many significant aspects of foster care remained untouched or came up only when the participants were leaving, thus indicating a need for continuing the groups beyond the allotted six sessions.

Thus far, the agency has held four series of group discussions for foster parents, each group containing from eight to 16 members, chiefly foster mothers. Because the meetings are held during normal working hours, only two foster fathers have been able to attend regularly. This we see as a shortcoming, particularly because of the importance of the role of the foster father in the life of the adolescent foster child.

The agency, however, has a real commitment to the group method as a helping process. In addition to its work with groups of foster parents, it is now holding group counseling sessions with adolescent foster children and is planning meetings with the natural parents of children in foster care. One of the latest groups formed consists of foster parents of adolescent boys who are having their own group counseling sessions with an agency staff member. The agency's goal is to have the staff members of the foster care division eventually develop such skill in working with both individual parents and groups that they will feel free to use either method.

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research and service have been combined in . . .

introducing FAMILY PLANNING CLINICS

to LOUISIANA

JOSEPH D. BEASLEY, M.D. ● CARL L. HARTER

● In these days of mushrooming social research, many people have voiced concern about the amount of research effort that results only in tomes on library shelves, the implications of their findings for community action buried in the stacks. Research, however, that is specifically related to a service goal can become the foundation not only for identifying community needs but also for building the services to meet those needs in a way that offers opportunity for further research. Thus, in Louisiana, an inquiry into the attitudes of various groups of the State's population toward family planning has resulted in the creation of the first family planning clinics in the State. These clinics are not only providing poor people with a service never before available to them but are also producing data that, when systematically analyzed, may have important implications for the design and operation of family planning clinics for disadvantaged people elsewhere.

The background

In 1964, no organized family planning clinics, either public or private, existed in Louisiana, and the State's progress toward formulating a policy concerning this type of health service was at a standstill. At that time, section 14:88 of the Louisiana Criminal Code, as interpreted by the attorney general in 1932, made it a felony to disseminate information about contraceptives or any birth control measures. While

persons who received medical attention from private physicians could usually get help with family planning if they so desired, the "medically indigent" people who attended public health centers and public hospitals had no way of obtaining such service. Legislative efforts to change the situation were of no avail. A bill introduced in the lower house to authorize the State Board of Health to start and maintain community educational programs focused on family planning was reported out of committee with no recommendation and was thus, in effect, killed. Thus, it became obvious that if any break was to be made in this stalemate, reliable information about the need for family planning services would have to be secured. Therefore, the Population and Family Studies Unit of the Tulane University School of Medicine's Division of Maternal and Child Health applied to the Children's Bureau for Federal funds to support such an investigation.

The project's first effort was to obtain data, through a questionnaire administered by personal interviews, from a "probability sample" of 368 men who had ever been married and 540 women who had ever been married or pregnant, aged 15 through 45, in New Orleans. (A "probability sample" is a group selected through a special sampling technique to be accurately representative of the total population. In this instance, 42 percent of the 908 persons in the sample were Protestant; 56 percent, Roman Catholic; and 2 percent, subscribed to other faiths.) The questions

they were asked were designed to elicit information on: (1) The respondents' knowledge of, attitude toward and practice of family planning; (2) the differences in fertility among different segments of the population; and (3) the family structure and family stability in two generations. Preliminary analysis, made in the summer of 1965, of the data secured from these questionnaires provided the following statistics:

- 71 percent of the women interviewed and 81 percent of the men did not know enough about the ovulatory cycle to know that the fertile period in the woman is approximately the middle 7 days between two menstrual flows.

- 34 percent of the women and 32 percent of the men did not know that pregnancy results not just from intercourse but from the union inside the woman of a male sperm with a female ovum.

- 12 percent of the women and 5 percent of the men did not know of any natural, mechanical, or chemical methods of preventing conception; another 12 percent of the women and 15 percent of the men knew of only one method.

- 40 percent of the women and 40 percent of the men said they would like to have more information about family planning methods; and 38 percent of the women and 45 percent of the men either said they had sufficient knowledge of family planning methods or were sterile or in a sterile union.

- 91 percent of the women and 91 percent of the men said they believed that couples had the right to decide for themselves when to stop having children.

- 92 percent of the women and 94 percent of the men said they believed that family planning services should be made available to the medically indigent.

- The number of pregnancies reported by the women came to an average of 3.30; their unplanned pregnancies, to 1.62. The men reported having "fathered" an average of 3.39 pregnancies, 1.35 of them unplanned.

These findings suggested that a large majority of the population believed that more family planning services should be available, especially for people who cannot afford private medical care. Many of the women had indicated that they would use clinic services if they were available.

The data also showed that one-half of the 112

Negro women in the sample had been pregnant before marriage, and that 31 of them were still single at the time of the birth of their first child. Among the 398 white women, 25 said they had had premarital pregnancies, and 2 said they had had a child out of wedlock.

Although further examination of the data is required to be sure, preliminary analysis suggests that women who begin their families with pregnancy before marriage are contributing more to the Negro birth rate than are those who begin with marriage. Such families tend to remain disorganized, for when a young girl gives birth to a child out of wedlock her chances of forming a stable union are delayed if not considerably reduced—prospective husbands must be able to support a child as well as the mother. Therefore, an economic drain on the mother's family usually continues for some time. Moreover, the family hardly has time to recover from the economic drain of raising one generation before it must turn to the problem of supporting still another generation.

There is also some evidence to suggest that the children of families that begin with an out-of-wedlock birth early in the mother's life in turn tend to begin families out of marriage at an early age, thus making for a rapid turnover in generations. As a result, disorganized families become an increasing proportion of the population as a whole.¹

Armed with these findings, the Population and Family Studies Unit worked with the State Board of Health to secure a reinterpretation of section 14:88 of the Louisiana Criminal Code. In August 1965, the State's attorney general issued a reinterpretation, subsequently approved by the Governor, making it legally permissible to operate family planning clinics in Louisiana if they were under the

Joseph D. Beasley, M.D. (right), and Carl L. Harter, Ph. D., have been director, and associate director, respectively, of Tulane University's Population and Family Studies Unit since its creation in April 1966 within the Division of Maternal and



Child Health, Department of Tropical Medicine and Public Health, School of Medicine. In June 1967, the department became the School of Public Health and Tropical Medicine, and the "unit," a "center" in its Department of Maternal and Child Health and Population. Dr. Beasley is a full professor in the new school.

supervision of physicians. This paved the way for the establishment of pilot family planning clinics for the study of the medical and social factors in the acceptance or rejection of family planning methods and services. Within a month, the Lincoln Parish Family Planning Clinic was in operation.

The rural clinic

The Lincoln Parish Family Planning Clinic, the first family planning clinic in the State, was established by the project in cooperation with the Louisiana State Board of Health as a part of the regular services of the Lincoln Parish Health Unit. Lincoln Parish, a rural parish (county) in northern Louisiana, was selected as the site for the first clinic and program because (a) the "clinic eligible" population was small enough (approximately 1,000) that everyone in it could be contacted and served in less than 2 years and, also, small enough to permit trial-and-error changes in the program's operation without disrupting service; (b) there was a high degree of cooperation between the personnel in the public and private health agencies in the area; and (c) the parish had characteristics typical of other rural and semi-rural areas in the South.

During the first 6 months of its operation, the clinic restricted its service largely to mothers who were in the postpartum period of childbirth. During this period, the project also conducted a survey among 249 Lincoln Parish couples who had had a child in the previous 5 years. (In this probability sample, 99 percent of the couples were Protestant and 1 percent, Catholic.) The same questionnaire was used as in the New Orleans survey and for the same purpose: To obtain data that could be used as a baseline in establishing procedures and guidelines for a parishwide family planning program. Completed in December 1965, the survey produced the following preliminary data:

- 87 percent of the women and 82 percent of the men did not know enough about the ovulatory cycle to know that the fertile period is approximately the middle 7 days between two menstrual flows.
- 47 percent of the women and 37 percent of the men did not know that pregnancy results from the union inside the woman of a male sperm with a female ovum.
- 15 percent of the women and 3 percent of the men did not know of any natural, mechanical, or

chemical methods of preventing conception; and another 19 percent of the women and 40 percent of the men knew of only one method.

- 71 percent of the women and 66 percent of the men said they would like to have more information about family planning methods; another 21 percent of the women and 32 percent of the men said they had sufficient knowledge of family planning methods or were sterile or in a sterile union.

- 96 percent of the women and 87 percent of the men said they believed that couples had the right to decide for themselves when to stop having children.

- 99 percent of the women and 98 percent of the men said they believed that family planning services should be provided for the medically indigent.

On the basis of data from this survey, as well as data from the health department's vital records that identified mothers at "high risk" of having complications in the event of another pregnancy, the project decided to broaden the scope of the clinic's services. Therefore, on March 1, 1966, the services were opened to all medically indigent mothers and married women in Lincoln Parish. Before this was done, however, the project's director got in touch with the religious, political, civic, and medical leaders of the area to inform them of the reasons for the clinic's establishment. All agreed to the principles that were to govern the clinic's operation.

In the clinic, all patients receive instruction on (1) the meaning of family planning and its relationship to family welfare; (2) the mechanism of fertilization and subsequent fetal development; (3) the types of available medically sound birth control methods and the advantages and disadvantages of each; and (4) the official positions of the larger religious denominations on family planning. After this comprehensive instruction, all patients have the opportunity, in private consultation with a clinic staff member, to decide individually which birth control method they want to use, if any. Patients who choose the rhythm method are given detailed instructions and continuing consultation on its use. Similarly, patients who elect the use of a contraceptive are provided with the appropriate equipment, instruction, and service. Since the program was developed as an integral part of a comprehensive maternal health service, all patients receive pelvic and breast examinations, a test smear for cancer, and, when appropriate, a postpartum evaluation.

Of the estimated 1,000 "clinic eligibles," 30 percent had received family planning information and services by September 1, 1966; that is, within 6 months after the clinic began full-scale operation. This amount of response in such a short period after the opening of the service suggests that the desire for family planning services indicated in the survey was real.

The project is now making the following studies in Lincoln Parish: (1) an experimental study of the effect of the method of recruitment and of the effect of "parity" (number of previous childbirths) on a woman's participation in a public health family planning program; (2) a comparative study of the effectiveness of two types of intrauterine devices in a public health family planning program; and (3) a fertility analysis, cost analysis, and analysis of service statistics.

The urban program

The next step in furthering the project's research on fertility and family planning was to try to establish and study a family planning program for the medically indigent population of a large urban area, specifically New Orleans.

The plan of action consisted of seven steps:

1. Determine the *Acceptability* of such a program to the community.
2. *Design* a program that would simultaneously provide adequate, efficient service to all eligible and interested patients and accumulate detailed, systematic data for medical and behavioral scientists.
3. Secure the *Support* of the community leadership—religious, civic, and political—for such a program.
4. Obtain the necessary *Money* to establish the program.
5. Put the program into *Operation*.
6. Evaluate the *Results* of the program and use these results not only to enhance the program but also to keep the community-at-large informed.
7. Make plans to *Extend* the program's services beyond the period of time encompassed by the study phase.

When the initial letters of each key word in these steps are combined, the result is the acronym "ADS

MORE." We believe that such a program will indeed add more to the health care and economic and social well-being of persons in the community.

With regard to the *acceptability* (step 1) of a family planning program to the people of New Orleans, the Unit had already found, through the family and fertility survey made there, that nine-tenths of both Protestants and Catholics believed that family planning services ought to be available to the medically indigent. Furthermore, a majority of the respondents from the lowest socioeconomic group had said they would like to have more family planning information. In short, the opinions expressed by the people in the survey sample indicated not only that a public health family planning program would be acceptable but also that such a program was actually needed. In fact, 84 percent of the people in the sample had said they were in favor of the establishment of either a tax-supported or a voluntary family planning program.

In drafting the *design* of the proposed program (step 2), the Unit had two main objectives: (1) to provide clinical services to interested, eligible persons in a manner consistent with the dictates of their consciences; and (2) to produce data for evaluative purposes.

The clinical program was designed to provide the same type of individualized service as the Lincoln Parish clinic, but to do this through a central clinic and five satellite clinics. Similarly, the plan for accumulating detailed, systematic medical and behavioral data was based on the experience gained in designing data-gathering forms for the Lincoln Parish Family Planning Clinic. This consists of a system of recording data needed for both following the patient's progress and evaluating the program.

From the beginning of its research on fertility and family planning in New Orleans, the Population and Family Studies Unit kept appropriate city offices, including the mayor's office and the local health and welfare departments, appropriate voluntary organizations, and the two large universities in the State, informed of what it planned to do and why and presented them with findings from the survey as these were obtained. Building relationships with these groups took 2 years, but the rapport thus established brought strong community support for the proposed clinical program. The Population and Family Studies Unit received letters endorsing the principles of its proposal from the Orleans Parish Medical Society, the Family Life Apostolate of the Archdiocese of New Orleans, the Orleans Parish

Department of Public Welfare, the City of New Orleans Department of Health, the Louisiana Association for Mental Health, the Charity Hospital of Louisiana at New Orleans, the schools of medicine of both Louisiana State University and Tulane University, Total Community Action (the local community action program, or CAP, in the "war on poverty"), and the Greater New Orleans Federation of Churches. The proposed program also received approval from the Social Welfare Planning Council, which represents the major voluntary health and welfare organizations in the city, and the local affiliates of the National Association for the Advancement of Colored People, the Congress of Racial Equality, and the National Urban League.

To operate a service and research program on the scale envisaged for New Orleans, *money* had to be secured to supplement the funds the Population and Family Studies Unit was receiving from the Children's Bureau. Additional support was eventually secured (step 4) through grants made by the Ford Foundation and the Rockefeller Foundation to the Population and Family Studies Unit and by the Office of Economic Opportunity to Total Community Action. By April 13, 1967, the Unit could count on \$2.1 million for operating the Orleans Parish Family Planning Demonstration Program for 3 years. To receive such funds and administer the program, a new nonprofit corporation was formed, the Louisiana Family Planning Program, Inc., with a board of directors composed of members of the faculties of the medical schools of Tulane and Louisiana State universities and of community representatives.

Program operation

The central family planning clinic opened in New Orleans on June 27, 1967. This marked the beginning of step 5—putting the plan into *operation*. The five proposed satellite clinics are expected to be providing services by late fall 1967 or early winter 1968. At present, the project's staff is preparing a procedural manual for use in training clinic personnel and to furnish to persons interested in learning about the details of the program. A similar manual has been prepared for the Lincoln Parish family planning program.

The basic data needed for evaluating the *results* of the proposed program (step 6) will be gathered with the use of a form for recording comprehensive data. In addition to the types of information usually

sought in evaluation of a family planning service—for example, rates of acceptance and continuance of the various methods of birth control and changes in the fertility rate in the neighborhood served—the Unit plans also to conduct inquiries into: (1) what is involved in the acceptance or rejection of a family planning clinic by members of a medically indigent population; (2) the effects of informal communication on the use of a family planning clinic; and (3) the effectiveness of instructions about family planning.

With regard to step 7, making sure the program's services *extend* beyond the research period, the service aspects of the programs have been designed as integral parts of the regular health programs of the participating agencies—the two medical schools, the city health department, the Orleans Parish Department of Public Welfare, and the State Charity Hospital at New Orleans. The principles and methods of operation and the record-keeping systems worked out by the Population and Family Studies Unit as a result of its experience with the Lincoln Parish and New Orleans family planning programs will be the guidelines to be followed by the State Board of Health, the State Department of Public Welfare and the State Department of Hospitals as they make plans to include family planning services as part of their developing health programs. The Population and Family Studies Unit and the Louisiana Family Planning Program, Inc., will serve as the coordinating agents for the development of a statewide family planning program. Plans are also underway for the design to be used in an expanded and coordinated program of maternal and child health for the indigent mothers and children of New Orleans.

In summary, the family planning activities of the Population and Family Studies Unit, Tulane University, have simultaneously provided a laboratory for scientific investigations and an avenue through which the university could be of service to the community. The objective, both in research and service, is to make it possible for couples to secure the information and services they need to plan their families so that they will be in a better position to develop the potential of each of their children.

¹ Fischer, Ann; Beasley, Joseph D.; Harter, Carl L.: The occurrence of the extended family at the origin of the family of procreation; a developmental approach to Negro family structure. Unpublished paper presented at the annual meeting of the American Anthropological Association, Denver, Colo., November 18–22, 1965.

an
**EDUCATIONAL
PSYCHOLOGIST**
in a
**PSYCHIATRIC
CLINIC**

ROBERT FRIEDMAN

● Poor schoolwork leads the list of complaints parents bring to orthopsychiatric clinics.¹

This is understandable, for our culture highly values formal learning. Success or failure in school greatly influences the behavior of children and the impressions they have of themselves and can critically affect the development of the ego. Clinical educational psychology, with its emphasis on the healthy development of the ego, has a special and essential contribution to make to psychiatric services for children and adolescents. The psychoeducational program described here is based on that proposition.

The setting

The program is unusual in that it operates not in a university, a hospital, or an independent agency, as psychoeducational programs usually do, but in a psychiatric clinic. The Department of Psychiatry at the Southern California Permanente Medical Group of Los Angeles, which conducts the program, offers comprehensive psychiatric inpatient and outpatient services at a central clinic on contract with several local labor unions, including the Retail Clerks and the United Auto Workers, AFL-CIO, and with Federal and State employees for service. In addition, the department provides consultative and educational services to the Kaiser Foundation Center for Child Psychiatry in Los Angeles, an agency offering low-cost, short-term psychiatric services to all 5-, 6-, and 7-year-old children in the community who are not

adapting well in school. The department has more than 40 professional workers, including psychiatrists, clinical psychologists, psychiatric social workers, and a speech therapist.

The psychoeducational program was set up late in 1964 after the department had explored the idea of including psychoeducational evaluation in the clinic's regular program and had found that the staff was very much interested. Its first act toward this end was to engage me as an educational psychologist specializing in the clinical evaluation and treatment of children and adolescents of normal intelligence who have been doing poor schoolwork and as a consultant to develop and supervise clinical educational services. An educational therapist was added to the staff, part time, in May 1965, in response to the growing use of the psychoeducational service by the regular staff members of the department. Psychoeducational consultation, evaluation, and therapy were made part of the regular program of the department and the center shortly after the therapist was hired, and in September 1965 the department started a training program for school psychologists and took on two interns from a nearby university.

In effect, the inclusion of a psychoeducational consultant in the traditional clinical team of psychiatrist, social worker, and clinical psychologist adds a fourth member who contributes expert knowledge in the area of learning disorders and the problems of school adjustment. The person in this position is responsible for psychoeducational evaluation; supervision of psychoeducational therapy; spe-

cial consultation with parents, staff members, and school officials; and the training program.

Some overlapping of duties among specialists is inherent in the structure of a traditional clinic team, and the work of the two psychologists at first did overlap. Our clinical psychologist is responsible for psychodiagnostic services, including treatment, consultation, and training; the duties of the educational psychologist are described above. Although both specialists often give the same tests to measure intelligence, personality, and perceptual-motor skills, close cooperation between them has eliminated duplication and has improved the effectiveness of the work of the team.

The program

Our program, modified and improved through experience, falls under four major heads—evaluation, consultation, treatment, and training.

Evaluation. Complaints about a child's schoolwork are particularly frequent at intake and may come from the child himself as well as from his parents or officials of his school. To properly consider these complaints we must often do a comprehensive psychoeducational evaluation of the child's academic skill and intellectual ability, the psychological correlates of learning applicable to him, the effect of his personality on his attitude toward and involvement in the learning process, and what his family expects of him in school and its attitudes toward achievement in school. A key issue in this evaluation is the way in which the child relates to the demands of a learning task—the degree of anxiety it arouses in him, the means he takes to reduce stress, the degree of passivity or aggressiveness he exhibits toward the task and toward the examiner as a figure of authority, and any other behavior related to schoolwork.

In addition to giving standard educational tests, we also follow informal evaluation procedures. For example, we use sample schoolwork sessions as a test because they call for much interaction between the child and the examiner and afford the examiner an opportunity to study closely the child's reactions to stress and frustration. Through interviews with the family—individually and as a group—the examiner can determine the effect the family as a group and its members as individuals have on the child's performance in school. We discuss his problems with his parents or with his brothers and sisters, separately or with the child present. Now and then, we ask par-

ents to explain or demonstrate the methods they use to help the child with his homework to determine whether the parents are providing the help in a constructive way. Interviews with the family as a group often uncover a specific relation between family dynamics and a child's performance in school.

In the first 18 months of the program, clinicians requested over 60 evaluations. Although specific recommendations for psychoeducational intervention or planning often followed these evaluations, sometimes the evaluation of a learning problem uncovered a condition calling for nothing more than a reassuring word to a child or his parents.

Consultation. We use the results of the evaluation in several ways. Sometimes we only report them to the referring clinician or discuss them at intake staff meetings. Frequently it is helpful for me to explain the results directly to parents in a conference with the clinician because the word of an "educational authority" often carries more weight than that of a clinician with parents who find it difficult to accept results and follow through on recommendations.

We often share with the school through written reports or informal meetings findings that teachers, principals, or school guidance workers can use to advantage.

I am available to the staff for special consultation about the many needs of their patients. For example, they may consult me about the merits of a school, for the right school is often critical in planning for some of the children we serve. When the issue of school placement is raised, I review information on available resources, including the experience we have had with these resources, and recommend a specific public, private, or residential school.

Occasionally, I have the unusual duty of acting as a cotherapist in a family therapy program when a case involves school problems that are exacerbating family tension, or when therapy for the child can be speeded up by involving the family more fully in treatment through concentrating on school problems.

Another of my duties is to make presentations to and to participate in staff meetings and seminars.

Treatment. With our patients—children and adolescents having trouble in school—we use psychoeducational therapy, a method of treatment centering on learning. (The term "psychoeducational therapy" as used here reflects a theoretical position put forward by my colleague, Edwin Strickler, and myself.) Our treatment includes the use of a wide range

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of practices, including remedial work, counseling, play therapy, and family therapy.

Remedial work to correct a lack of skill a child needs in school is an important part of treatment, but its results are not themselves the major goal. We emphasize, rather, making a positive change in the child's attitude, increasing his motivation, and modifying personality traits that negatively affect his adjustment to school. Our treatment is unusual in the scope of its theoretical conception and in the degree to which it is an integral part of a complete psychiatric service. For example, we provide psychoeducational therapy as a single treatment-of-choice and consider it as a primary, not an adjunctive, service. When the child's learning difficulty can apparently be resolved by tutoring only, we refer him to a school or another community resource offering the kind of service he needs.

More than 35 children and adolescents have been involved in the therapy to date. The therapeutic method we must frequently use at first is this: we try to establish a warm, accepting relation between the child and the therapist and to strengthen the relation by giving the child an opportunity to attain success in school. To help the child achieve this success, we must usually combine remedial teaching with opportunity for cathartic release of feelings by the child and for exploration and interpretation of emotions and behavior by the therapist. Getting the child to talk about his feelings concerning schoolwork and then getting him to see and understand the interaction between his feelings and his schoolwork is frequently the next step in therapy. As the child's relation with and confidence in the therapist grow, his academic skill usually improves. We find, however, that a skill mastered in a therapy session is not always used in the classroom. If it is not, then the discrepancy between performance in the clinic and in the school becomes the focus of attention and of the process of "working through." Exploring

fears, inhibitions, disturbed ideas of object relations, a negative attitude toward authority, and difficult relations with family and other children may at times be the "content" of treatment. The therapist is always free to work with whatever behavior or feelings come out in the therapy session.

The case of Don D illustrates our usual method of working with children:

When Don began treatment at the age of 8, he was an extremely nervous boy and was very much afraid of facing schoolwork, especially reading. At first we gave him very easy material to read, which he was soon able to do. With success in reading, his stress diminished and he was able to reflect on and accept his feelings about reading—and even to say "I don't want to read." We then explored the reasons for his resistance to learning and found that his reading problem was tied up with denial of many important emotions, including his reactions to his mother's overprotectiveness and his father's harshness. We also found that Don thought that learning to read meant growing up and growing away from his mother. Also, Don had linked the denial of sexual matters and the ignoring of issues raised by curiosity about sex in his home to resistance to seeing words and sentences.

Gradually, the therapist helped Don overcome his sensitivity to visual stimuli connected with mother-son and man-woman relationships through the use of picture stories and puppet play. To help Don see that his negative attitude toward school was keeping him from reading as well in the classroom as in the clinic, we had him attend tutoring sessions with another boy with similar problems. The boys' spontaneous interaction and their comments about school and therapy focused attention on the attitude toward school that was keeping them from doing better work. These sessions helped Don become more comfortable with learning tasks at his grade, and after 19 months of treatment, he did satisfactory schoolwork. We also found that he was able to recognize, tolerate, and handle long-repressed and troublesome feelings and fear—an improvement we considered at least as important as the improvements he has made in his schoolwork.

Other examples of the use of these or similar methods in treating such children exist in the literature,²⁻⁵ but the case of Stuart S, one of our clients, illustrates the use of an unusual method of treating a child with a problem in learning.

Stuart, a 9-year-old boy who exhibited great passive resistance to learning, had been exposed to much intellectualized talk in the home about feelings, emotions, and attitudes. A psychiatric social worker was seeing both his father and mother in individual therapy sessions. From the beginning of Stuart's treatment at the clinic, his therapist met his resistance forcefully and tenaciously with an attitude that said in effect, "You can do this hard work if you try, and I expect you to try." After a long struggle, which included many sessions in which the two said very little of meaning to each other (but in which there was much transactional content, that is, the child and the therapist "communicated" by silence, actions, or motions with each other), the boy was able to see the connection be-

tween his wish to remain an infant and his poor achievement in school.

The therapist speeded up the therapeutic process by involving the mother in several sessions with Stuart, getting the father to take part in the treatment hour as a teacher-authority, and holding several family group meetings. As a result, the father, who had been passive toward his son before treatment started, eventually assumed his duties as a father with Stuart and his change helped the child take a more aggressive attitude toward learning and improve his attitude toward and achievement in class.

Although we conduct most psychoeducational therapy individually, we do carry on some work with small groups because we recognize the potential value of work in a small group as a transition from individual therapy to the classroom, especially for children who have been excluded from a public school because of their unacceptable behavior. For the most part, such children are hyperactive, highly distractable, and disturbed, and they find it very difficult if not impossible to share the teacher's attention with other pupils, to work when other children are present, or to work or play with other children. If a child can acquire enough control to act as a social being in a classroom, at first with only one other child, later with several children, the probability of his returning to the classroom permanently will be greater. Our experience with a group set up for this purpose is encouraging, and group treatment is now part of our program.

Training. Recently revised requirements for school psychologists in California increase the emphasis on supervised internships. Because we concentrate more than most clinics on school problems, our clinic offers an appropriate placement for advanced graduate students. The training experience our clinic offers includes opportunities to attend intake sessions, treatment sessions, and seminar staff meetings, as well as to complete assignments for psychoeducational diagnostic studies, counsel parents, and conduct psychoeducational therapy. As a consultant, I closely supervise the work of the interns.

In addition to giving breadth and depth to clinical study, the internship enables the trainees to acquire a realistic idea of how a psychiatric clinic operates, because such a clinic is the kind of service to which they will make many referrals in their later work.

In turn, they can pass on a better understanding of both the merits and limitations of psychiatric services to teachers and other school people.

At present, we have in training one school psychology intern from the University of Southern California and one from the University of California at Los Angeles.

A summing up

To sum up this report on the clinic, our experience with the program supports earlier findings regarding the merit of clinical educational services in the orthopsychiatric clinic.⁶⁻⁸ In addition, I find that research on such significant questions as the influence of personality on learning and on the potential for treatment with psychoeducational therapy needs to be designed and carried through systematically.

The link between education and psychology offers many opportunities to use creative methods in working with a child in the clinic and in the school. I am firmly convinced that clinical educational psychology can make a significant contribution to a greater understanding of the dynamic interaction of teacher and pupil. What is the real challenge such a program must meet but to help all schoolchildren fulfill their potential for growth?

¹ Rabinovitch, R. D.: Reading and learning disabilities. In American handbook of psychiatry (Silvano Arieti, ed.) Basic Books, New York, 1959.

² Axline, V.: Nondirective therapy for poor readers. *Journal of Consulting Psychology*, March-April 1947.

³ Ephron, B. K.: Emotional difficulties in reading. Julian Press, New York, 1953.

⁴ Friedman, S. S.: Remedial therapy with a 12-year-old incarcerated delinquent. *The Reading Teacher*, April 1966.

⁵ Prentice, N. M.; Sperry, B. M.: Therapeutically oriented tutoring of children with primary neurotic learning inhibitions. *American Journal of Orthopsychiatry*, April 1965.

⁶ Blom, G. E.; Rudnick, M.; Searles, J.: Some principles and practices in the psychoeducational treatment of emotionally disturbed children. *Psychology in the Schools*, January 1966.

⁷ Miller, D. D.: Language and learning skills: functions of the educational psychologist in a psychiatric setting for children. *American Journal of Orthopsychiatry*, March 1962.

⁸ American Association of Psychiatric Clinics for Children: Tutorial program for troubled children. *Newsletter of the American Association of Psychiatric Clinics for Children*, February 1963.

CHILDREN COPE WITH CRISIS

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Dr. Robert Coles dedicates his book "Children of Crisis: A Study of Courage and Fear"* "to the children of a coming South," and he quotes the Biblical verse: "And Moses sent them to spy out the land of Canaan, and said unto them . . . see the land . . . and the people that dwelleth therein, whether they be strong or weak." Thus he sets the tone of his observations and reflections. He is concerned with the sources of strength and the ways in which children and their supportive parents, grandparents, and teachers struggle with the fear generated by the strife aroused during the process of school desegregation.

He writes as a man of deep sensitivity, reflectiveness, and love, and with the insight of an "anthropological psychiatrist" uncommonly receptive to people's feelings. His own strength includes an unstinted autonomy and integrity that make it natural for him to describe children very simply, through their own language of picture and word, without substituting complex diagnostic clichés for fresh formulations based on insight.

Dr. Coles undertook his studies of the children caught up in the desegregation movement and "the people who nurture them, teach them, and on occasion fail them terribly" in 1958. He has continued to see many of the children and families periodically over the ensuing 9 years. His method of study is that of direct observation, "talking

with people, listening to them, watching them—and being watched by them" and "taking a long time; enough time to be confused, then absolutely certain and confident, then not so sure but a little more aware of why one or another conclusion seems the best that can be argued [for]. . . ."

Dr. Coles tried to find out how children managed under stress, that is, abnormal and dangerous circumstances. Children and adults who entered the mainstream of the desegregation process, or were caught up in it, he believed, have "discernible cause to feel nervous, to develop . . . symptoms in both mind and body." He was interested in whether they did so and, if they did, how and when they did; and also who chooses which kind of danger and for what reason. His deepest interest was in learning what makes "for survival under stress, for endurance, for courage against grim odds; indeed, for plain good health. . . ."

He was also interested in what the child's mind makes of the world—of politics, race, and the power of money—and why one person is satisfied to make peace with the world while another takes the world on and tries to change it. He felt that as a clinician interested in what goes on "inside" others, he was "as qualified as anyone to go back and forth, to see how the two worlds (outside, inside) connect, blend, engage. . . ." That is, he wanted to understand the connection between a child's or a man's thinking and the world's state of affairs. So, he went into places where certain people were up against difficult times "so that their lives, like those of the sick, may have [had] something to teach the rest of us."

Dr. Coles' intellectual heritage is rich. He draws deeply from Erik Erikson's concepts and vision of the everyday relatedness of the human mind to social institutions and to history, and from the simplicity of Anna Freud's observations of English children under air attack and children salvaged from concentration camps, and her examples of combining observation with practical service. He also draws perspective from Tolstoi and a sharpened awareness from Oscar Lewis, Bruno Bettelheim, Faulkner, and Kafka. Doubtless these writers, along with an apparent Biblical heritage, contributed to the poise, grace, and dignity of his writing and of his feeling for people.

Self-image

Dr. Coles gives us vivid action portraits of young children, both Negro and white, who participated in the desegregation of schools in Atlanta and New Orleans and of their teachers and parents. Protesting and nonprotesting integrationists in the South and even segregationists are all presented with understanding.

He includes pictures drawn by two first-grade children, Negro Ruby and white Jimmie, as direct evidence of the everyday stress of being a Negro child in a rejecting white world. The drawings reveal both children's sense of the Negro child's incompleteness, inadequacy, or distortion through small figures drawn with shaky lines, missing fingers and features, and lack of vivid detail.

I found Ruby's pathetic representation of her self-image especially shocking in contrast to the clarity, vigor, and spontaneity of *colored children in a*

*Coles, Robert: *Children of Crisis: A Study of Courage and Fear*. Little, Brown and Co., Boston, Mass. 1967. 401 pp. \$8.50.

colored world—as with children in Nigeria—and even in contrast to the vigor of many Negro children in a town like Topeka, Kans., where schools have been integrated for a dozen years.

Dr. Coles learned about the coping patterns of the Negro children not only from them but also from observant white children aware of their experiences. He learned that before desegregation George, who told about crying when a beloved Negro maid left his family when he was 5 years old, had completely identified with the Southern attitude toward race and with the Southern resentment toward Northerners who do not realize the love some Southerners have for the individual Negroes they live close to. He suggests that perhaps this background of early attachment, along with a native intelligence, underlay George's sensitivity to the behavior of Lois, the new Negro girl in his class.

George understood the girl's anxiety but was confused by her good humor. He observed her vigilance as she tried to see what happened around her while she was afraid to move her head and look. He was aware of the tension in the room, "so thick you can almost cut it," and said that the teachers were as nervous as the pupils. He thought that perhaps the girl's "silly smile" reflected her awareness that the white children were suffering too. He was aware of her loneliness: only one or two would sit near her; no one would work with her in the "lab" but the teacher.

George thought at first that the presence of Lois ruined everything for his class's last year at school. However, as time went on, he developed increasing empathy for her. He felt the strain was beginning to tell, that she tried hard to find a reason to smile but could not, so she sat there most of the time pretending to read or write. He even admired her way of holding back from revealing how smart she was because she was afraid it would make the others jealous and mad. He became aware of how strong her staying powers were.

In such reports, Dr. Coles shows us how deeply human both the white and Negro children were; how inexorably their human respect for courage, for one another's decency, slowly brought some of them together; how in many instances the experience of being together melted the rigidity of prejudice.

He tells about a white mother who in-

voked the Lord's name to give strength to her belief that every human being deserves respect; and about a Negro mother who drew support from the idea of an all-loving Lord and told her children when they asked about their color that "the Lord likes everyone because He makes everyone. . . . No one knows what color He is."

But the Negro child rejected by the white world struggles not only with the question of whether he is all right; he also struggles to get an explanation. A little Mississippi girl said, after drawing a picture of herself, "That's me, and the Lord made me. When I grow up my momma says I may not like how He made me, but I must always remember that He did it, and it's His idea. So when I draw the Lord He'll be a real big man. He has to be to explain about the way things are."

We see here the alert, sensitive child trying to make sense of an incomprehensible situation, part of the effort every child makes to achieve an orderly, intelligible conception of the world. The children were observant: "The colored don't get good streets with cement on them as easy as the white."

Supporting resources

The Negro parents tried to teach their children how to cope with discrimination. Said one mother: "We have to live with one another, black with white . . . you have to teach your children to know what's dangerous and how to stay away from it. . . ."

Tessie and two other Negro girls were the only pupils at school during their first year of "desegregation." All the white pupils had boycotted. Her grandmother remarked shrewdly: "I kept on telling Tessie she'd never have it as good again, all that building and teachers to herself and everything. Take advantage of the white man's mess, because it'll work for your gain, that's what I said to her when I thought she needed a little helping word here or there."

Tessie's mother wanted her daughter to go to a desegregated school but she worried about the strain of it upon her daughter and herself. "The truth is I might have taken Tessie out. . . . I held firm because my husband held firm, and we both held firm because of Tessie's grandmother . . . she never gets scared. . . ." Tessie's mother said: "I try not to go beyond each day . . . if

you can get your strength up for the present, the future will take care of itself." She answered abuse with silence.

Tessie's grandmother told her, "It doesn't even matter if it's easy or hard for you at school. It's *going* to be hard, some time or other it's going to be hard in this world and Tessie girl, you'd just as well start getting used to it now." To Dr. Coles, the grandmother said, "Tessie and I eat grits before going through those mobs and we eat ice cream after we come home from them." Thus the wise grandmother helped with perspective and earthy sustenance to maintain the nerve of her beleaguered granddaughter.

Tessie had her own resources, too; she was a fierce, stubborn, willful child. But she *became more contained* once she started school under the watchful eyes of the mob. "She liked to draw . . . she could give representation to her tormentors, to her dread of their vengeance, to her feelings of weakness, to her natural wish to escape, to be a little white girl living a less turmoil-filled life." This capacity to clarify her feelings and thus to master them was for her another major resource for coping.

She kept the drawings for a while, looked at them from time to time, and absorbed them: then when she had come to terms with the fantasies they represented, she gave them to Dr. Coles. "I know it's scary sometimes . . . but not as scary as what I can dream up. . . . So I told Granny that as bad as they make it for us, the stronger I'll get, because I'll beat them to the punch by imagining it even worse than it is . . . everything goes fine with the whites until I get sick and stay home. Then, when I come back to school, it takes them a day or so to get used to me, all over again." She helped herself by contrasting reality with fantasy. Having mastered her own fear, she could even understand the plight of the white children.

Effects on children

Dr. Coles makes the nature of the struggle vivid to the reader—the constant threats "We'll kill you . . . poison you . . . choke you. . . ." He gives accounts of terror, humiliation, repudiation beyond any told in newspaper or TV accounts. Yet, he reports little evidence of children being overwhelmed by

their experience or becoming physically or mentally ill, disorganized, aggressive. Perhaps no breakdown occurred because of the self-selection process that permitted only the most confident Negro parents to sign up for their children to attend desegregating schools; or because of the "screening" process used in some schools to eliminate "poor risks" and select the most stable children.

Dr. Coles is also concerned with another problem: to what extent is it all right to allow children to participate in the movement, to face the mobs? His answer: "When we find out what happens to them if they don't protest, we will find out about children in daily subjection who have been asked to forfeit their freedom by the decision that they must endure tyranny rather than face 'danger' or 'trauma'. . . . What can be worse psychologically and spiritually for any child?"

Yes, but . . .

It may seem strange for me to add a "Yes, but . . ." to Dr. Coles' presentation. But I wonder whether this emphasis does not overlook the question of who can afford to battle for the group. The Armed Services with good reason exclude men vulnerable to breakdown. In the internal war of desegregation, some such screening may also be needed. In the South it has been provided directly by some principals and indirectly by others who asked for applications. In the North, where some large-scale integration has been attempted by arbitrarily assigning children to schools out of their own neighborhoods, there may be more serious effects on *some* children: fatigue or a divided life in which the range of standards and life styles in different settings is too great for young children to integrate.

Dr. Coles reminds us that children participated in the Underground in Europe, boycotted Quisling's teachers in Norway, sang songs of protest in Danish schools, helped derail German trains in Holland, and even murdered Gestapo agents in France. They fought for survival and formed gangs to seek food and shelter to support one another. Some learned in German concentration camps the "value of freedom and of life itself." But many did *not* survive, and we must not forget this.

Rugged children may thrive on chal-

lenge. But when we focus on the strong, we forget children all over the world who do not survive—those who die of marasmus or are mentally stunted and depressed in foundling hospitals; those who fill our child psychiatry clinics with more troubles than can be eased; those who grow into adults without hope, who join the ranks on skid row or fill our prisons.

The value of emphasizing the toughness of the survivors is to illustrate how amazingly wide the range actually is from strength to vulnerability, how hard it is to gauge the line between adversity that strengthens and adversity that destroys; and to challenge us to study still more intently the coping efforts and support that contribute to survival. Dr. Coles' eloquent account of the survival techniques of the strong is a gift to the science of human development, of child psychology and psychiatry, of social change.

But, to have a complete picture, we need a comparably sensitive record of what has happened to *all* the children in New York City who were "bussed" out of their home neighborhoods to integrated schools. Here we might find not only heroes like those Dr. Coles has described, but also victims of desegregation in terms of educational and emotional losses.

As I read the book, I was impressed by several recurrent themes:

1. The support given by Southern *mothers*, Negro and white, to their children who were carrying the burden of integration—a support often rooted in a deep commitment to a good education; the tough, sometimes stubborn realism, frustration tolerance, capacity to take risks, typical of these mothers and their husbands (often more passive) and in some cases the children's grandmothers or their teachers and ministers.

2. The struggle of children to learn to accept and understand the different colors "God made" people to be.

3. The learning process and adaptational steps involved in coming to terms with desegregation, especially as these steps were imposed upon a few recalcitrant fathers who at first opposed their sons' going into the civil rights movement.

4. The role of empathy, compassion, and affection in helping white children and adults appreciate the experience of the Negro children—both in those

who were freely moved by these feelings and those with immobilizing conflicts between such feelings and their prejudice.

5. The suffering, disillusionment, and despair that sometimes overcame but did not stop the young people who had hoped to accomplish visible changes rapidly and who came to realize that the task of integration would take years or a generation or two.

6. The inner vitality, release of energy, and integration of personality that so many children seemed to derive from the experience of living, acting, feeling in a way consistent with their ideals and beliefs. I have seen this in other groups deeply committed to a goal—in Israel in the early years of independence and in a new college committed to uniquely individualized education. Fighting for what one believes to be right mobilizes energies from all layers of the personality—conscience, ego, and primitive forces of love and aggression. Moreover, the opportunity to defeat an enemy such as prejudice in righteous battle helps a person to transcend the small bitter conflicts that so often block the full use of personal resources.

7. The progressive stimulus of progress itself.

collected readings

PERCEPTUAL DEVELOPMENT IN CHILDREN. Edited by Aline H. Kidd and Jeanne L. Rivoire. International Universities Press, New York. 1966. 548 pp. \$12.50.

REVIEW OF CHILD DEVELOPMENT RESEARCH, vol. 2. Edited by Lois Wladis Hoffman and Martin L. Hoffman. Prepared under auspices of the Society for Research in Child Development. Russell Sage Foundation, New York. 1966. 598 pp. \$8.

MONTESSORI FOR THE DISADVANTAGED: an application of Montessori educational principles to the war on poverty. Edited by R. C. Orem. G. P. Putnam's Sons, New York. 1967. 191 pp. \$4.95.

THE UNWED MOTHER. Edited by Robert W. Roberts. Harper & Row, New York. 1966. 270 pp. \$3.25.

BOOK NOTES

CHILDREN: development and relationships. Mollie S. Smart and Russell C. Smart. The Macmillan Co., New York. 1967. 582 pp. \$7.95.

A textbook for students preparing for professional work with children, this book, according to its authors, integrates the teachings of Erik Erikson on the stages of personality development and of Jean Piaget on the stages of intellectual development. The first chapter gives a general view of growth and development; the others center on the prenatal period and infancy, the preschool years, the elementary school years, and adolescence.

POVERTY IN CANADA AND THE UNITED STATES: overview and annotated bibliography. Benjamin Schlesinger. University of Toronto, Press, Toronto, Ontario, Canada. 1966. 211 pp. \$5.

By way of introduction to this book, four social work educators—one Canadian and three Americans—present a “critical overview” of the efforts of their nations to end poverty. The annotated bibliography of nearly 600 articles, books, summaries, and monographs describing these efforts that follows is divided under such topics as family life, economics, education, social services, social work, health, housing, and law.

INTERNATIONAL BIBLIOGRAPHY OF RESEARCH IN MARRIAGE AND THE FAMILY, 1900-64. Joan Aldous and Reuben Hill. University of Minnesota Press, Minneapolis, for the Minnesota Family Study Center and the Institute of Life Insurance. 1966. 508 pp. \$15.

This volume is the product of the first phase of the Minnesota Inventory of Published Research on Marriage and Family Behavior—“identification of the topics which have been empirically investigated by marriage and family

researchers.” It lists 12,850 research reports and theoretical essays published from 1900 to (November) 1964 in the United States and abroad in which marriage or the family figured in some way. Prepared with the use of a computer, the volume has five sections: a key-word-in-context (KWIC) index; a subject index; a complete reference list; an authors list; and a periodicals list.

THE DEVELOPMENT OF THE INFANT AND YOUNG CHILD: normal and abnormal. R. S. Illingworth. The Williams & Wilkins Co., Baltimore, Md. 1966. 378 pp. \$10.

The third edition of a work first published in 1960, this book describes the mental development of the infant and preschool child from the point of view of everyday pediatric practice.

The author has enlarged the chapters on prenatal and environmental factors to include recent information and has added new chapters on reflexes and reactions of the newborn child, the assessment of maturity, and the assessment for adoption.

ROOM TO GROW: a study of parent-child relationships. Carroll Davis. University of Toronto Press, Toronto, Ontario, Canada. 1966. 214 pp. \$6.

Illustrating her points with the “emancipation profiles” of seven children she followed in a longitudinal child development study from the ages of 5 to 20, the author presents a theory about the process in which a child grows from dependency into a self-directed person who is “emancipated” from his parents’ direction. She points out that a child seems to become free of his parents by taking “portions of his life into his own hands” as he gains confidence and competence, and that the attitude of the parents toward the process is a force greatly affecting the child’s progress and one around which other influences seem to cluster.

Individuality and emancipation are inseparable, as they are both derived from the quality of the parent-child relationship, the author contends. This relationship is constantly changing, and its balance and freedom determine the degree of reciprocal trust between child and parent, she adds.

EARLY CHILDHOOD DISTURBANCES, THE INFANTILE NEUROSIS, AND THE ADULTHOOD DISTURBANCES: problems of a developmental psychoanalytic psychology. The Psychoanalytic Study of the Child Monograph No. 2. Humberto Nagera, M.D. International Universities Press, New York. 1966. 95 pp. \$3.

The author of this monograph approaches the question of childhood disturbances from a developmental point of view. After expressing his dissatisfaction with the content of today’s thinking on diagnosis, he maintains that analysts cannot continue to call all childhood disorders “infantile neurosis” or to look for solutions in “any one phase of development.” He also rejects the idea that “faulty object relationships” and “faulty ego development” are the only sources of disorder.

He reports that his method of analyzing childhood disorder is to give due attention to the developmental processes in all aspects of the personality (drives, ego, superego, and object relationship) “to enable the clinician to test pathology against the right developmental background and to take into account the ideal picture of normalcy.”

ROLE PLAYING FOR SOCIAL VALUES: decision-making in the social studies. Fannie R. ShafteI. Stories by George ShafteI. Prentice-Hall, Inc. Englewood Cliffs, N.J. 1967. 431 pp. \$5.75.

As defined in this textbook for the classroom teacher, role playing serves two major functions in the classroom. It can help the teacher in educating children for citizenship and in conducting group counseling in her class. The authors have divided the book between theory and methodology and materials (problem stories that present situations for children to work out in class concerning individual integrity, group responsibility, self-acceptance, and managing personal feelings).

observations from
a visit abroad . . .

CHILD CARE IN OTHER COUNTRIES

MARTIN GULA

Specialist on Group Care, Children's Bureau

● Political commentators have noted in recent years a growing universality in the social and economic conditions influencing families and children in economically developed countries, despite their political structure. But, is there universality in the kinds of social services provided in these countries to assist families and children who are handicapped by these conditions?

I wondered about this during a 3-week visit recently to the British, Danish, and Israeli parliamentary democracies and the Polish and Yugoslav socialist republics. Three weeks is too short a period for profound observations. However, my impression is that where a child lives makes some difference in the services his country develops because of diversity in political philosophy, tradition, and culture; but also that these differences are beginning to be less apparent as nations are faced with common problems.

The most highly populated country I visited was England, which has about 15 million children under 18 years of age. The smallest was Israel, which has less than a million children. But social

workers in all five countries reported the same conditions affecting families and children—increasing urbanization; rising living costs; inadequate housing; employment of mothers; shortage of day-care resources; need for new patterns of social work leadership; and inadequate delivery of welfare services.

These conditions as they exist in many parts of the world have been reported on previously in *CHILDREN*.^{1,2} Therefore, I will confine my comments to resources for day care and foster care and social work leadership as reported to me by government officials and social work leaders in these particular countries.

Day care

Various types of day-care arrangements are available in each of these countries, but nowhere in sufficient quantity to meet the need. In Denmark, for example, an infant or toddler may accompany his employed mother to the establishment where she works; a day nursery is provided within the establishment; the mother nurses and feeds the child there; she may also be called upon to substitute for an absent or sick member of the nursery staff; and she picks up her child immediately at the end of the workday. Danish employers like this plan because it reduces employee turnover, fatigue, and absences.

Other mothers use a community day nursery or day-care center. In all types of centers, the operator is required by Danish law to have 2 years of full-time training, which they usually get at government expense. The training includes classroom and supervised practice instruction. However, with a population of only 5 million people, Denmark still needs day-care facilities to accommodate about 30,000 more children.

In Warsaw, the toddler of the employed mother in many instances can remain home because his "babeha" (grandmother) lives with him and his parents. But the proportion of grandparents living with married children or sons-in-law is decreasing as the housing shortage eases. Grandparents are beginning to find jobs or they become eligible for retirement income and find it possible to live alone. Thus, more demand is made by mothers for day nurseries, baby homes, nursery schools, and 5-day boarding "crèches." Poland doubled the number of its crèches and

nursery schools during the 1950's to serve over 350,000 children. The number is steadily increasing.

In Israel, the toddler's mother encounters more difficulty in finding day-care resources. Unless she lives in a kibbutz (only 5 percent of the population do), she will have to seek out a relative or neighbor to care for her child or a commercial nursery or a voluntary organizational day-care center, just as a mother in the United States does.

If the mother lives in a kibbutz, her toddler lives in a "children's house" with four or five other toddlers during the day. He visits with his mother for several hours in the early evening and returns to sleep in the children's house at night. But these traditional kibbutzim child-rearing practices are beginning to change. Young kibbutzim couples are pressing to be allowed to keep their young children at home with them overnight and to use the children's house for day care only.

In most of these countries, many day-care facilities rely on untrained persons to care for the children. But in each country, social work leaders, aware that the early years of childhood are the formative years, are working to have such facilities improved or replaced by centers run by trained personnel who can contribute positively to the child's social, emotional, and educational development.

Foster care

As in this country, physical or economic breakdown in families is reported to be decreasing as a major reason for placing children in institutions and foster families. But psychological breakdown in families is increasing in such cities as London, Tel Aviv, and Belgrade with the result that growing numbers of emotionally disturbed and mentally retarded children are in need of care and treatment beyond their family's capacity to provide. The cities are also experiencing an increase in the number of adolescents who need care away from home because of their family's inability to cope with them.

Because most of these children present difficult behavior and complex problems, the countries are facing a need to improve the quality of traditional foster homes and child-rearing institutions at a time when they are find-

ing it difficult to recruit urban foster homes and staff members for the institutions.

England has more children in foster family homes (30,000) than it has in institutions (24,000). Foster family programs are relatively small in the other countries. Poland, for example, has only about 250 foster families, but it has about 360 child-caring institutions caring for more than 42,000 children.

Denmark is increasing the public proportion (99.5 percent) of the financing of its 300 child-caring institutions; developing smaller group homes; and operating a national training program for infants' nurses, day-care and kindergarten staff, leaders for boys' and girls' clubs, and institutional child-care staff.

Denmark's national training program for child-care staff was established in 1958 in a former 90-room royal palace in Jaegerspris. About 75 young men and women are trained there annually for work in public or voluntary institutions. A full-time director and five faculty members, provide the students with 1,500 hours of classroom instruction and supervised practice over a 12-month period. Plans are to develop six more of these "colleges" to train 400 students annually. An advanced training program, also run by the government, is available in Copenhagen. The Children's Department of the British Home Office operates a similar and even larger training program.

In Yugoslavia, several rural villages have been made into "foster family villages." The unsophisticated nature of the peasant families, however, precludes their being used for the care of children with complex developmental problems.

In Bristol, England, public child welfare officers are experimenting with a ring of small, public agency-owned group homes near the perimeter of the city. These homes are used for many purposes, such as emergency shelter and foster care of adolescent homeless children, family groups of children, and children too disturbed for traditional foster family homes.

Professional leadership

Denmark, Poland, and Yugoslavia have relied heavily on volunteers, citizens committees, and factory welfare committees to respond to the needs of

the family with a child in distress. England and Israel have trained social workers in undergraduate college programs.

But none of these countries has developed graduate professional schools of social work similar to professional social work schools in the United States. However, in England, Denmark, Poland, and Israel perhaps more creative use is made than in this country of undergraduate-trained workers and citizen volunteers in responding quickly to families in distress.

In all five countries the ministries of welfare and the social work leaders are pressing for new patterns of professional leadership, but in each the patterns are developing in different ways. Denmark, for example, has a central children's bureau and about 50 citizen volunteer district children's committees to serve a total of about 750,000 children and youth under 21 years of age. Recently, its parliament passed legislation to train and introduce "family counselors" in urban areas especially for disturbed and delinquent children and their parents.

In Warsaw and Poznan, universities are developing undergraduate training schools for "social assistants" who will help coordinate the efforts of the 60,000 volunteers in Poland who work with families and children in the 400 "poviats" (counties).

In Israel, institutions for dependent and delinquent children, as well as a new day-care center for retarded children, are experimenting with group-work and casework services for children and parents.

In all five countries, national ministries and voluntary child welfare organizations express deep interest in and special concern for the welfare of children without parents. The question they all face is how to develop community services and resources to strengthen the family and improve foster family and residential group care for children who must live away from home and in doing so to use all local health, education, and mental health resources.

¹ Close, Kathryn: Social strategists for urban development. *Children*, November-December 1966.

² Oettinger, Katherine B.: Youth and youth services in England. *Children*, March-April 1967.

Guides and Reports

CHILDREN AND YOUTH AT MID-DECADE: the report of the Mid-Decade Conference on Children and Youth, Washington, D.C., April 12-15, 1966. National Committee for Children and Youth, 1145 19th Street NW., Washington, D.C. 20036. 1967. 217 pp. \$2.

Includes the texts of addresses and reports made at the conference and summaries of the work groups.

SUCCESSFUL FOSTER HOMES: an exploratory study of their characteristics. Patricia W. Cautley, Martha Jean Aldridge, and Bernard Finifter. Foster Homes Research Project, Wisconsin Department of Public Welfare, Madison, Wis. 53702. June 1966. 232 pp. A limited number free on request from the Department.

Reports in detail on a study whose findings were summarized in the November-December 1966 issue of *CHILDREN*, p. 247.

UNMARRIED PARENTHOOD: clues to agency and community action. National Council on Illegitimacy, 44 East 23d Street, New York, N.Y. 10010. 1967. 90 pp. \$2.50.

The nine papers included discuss aspects of parenthood out of wedlock in the AFDC program, in urban ghettos and in rural areas; problems in and approaches to the provision of services; the legal rights of unwed parents; and sex education as a way to prevention.

ENQUIRY INTO SUDDEN DEATH IN INFANCY. Ministry of Health. Her Majesty's Stationery Office, London. Available from British Information Service, 845 Third Avenue, New York, N.Y. 10022. Reports on Public Health and Medical Subjects No. 113. 1966. 52 pp. 90 cents.

Reports on the findings of studies of sudden and unexpected deaths of infants in Cambridgeshire and in 12 boroughs of London, conducted mainly between January 1958 and October 1964 by a steering committee appointed by the Ministry of Health.

HERE and THERE



Nursing education

The National League for Nursing and the American Nurses' Association have set up an autonomous commission to study the needs in and objectives of nursing education. Called the National Commission for the Study of Nursing Education, Inc., the 15-man commission represents many fields, including business, health, education, and social sciences. W. Allen Wallis, president of the University of Rochester, will head the 3-year study. Grants from the Avalon Foundation and the W. K. Kellogg Foundation and an anonymous gift are supporting the study.

The objectives of the commission are: to determine what community needs in nursing care and services the profession can reasonably meet; to determine what resources are necessary to provide nursing education and good economical nursing services; to evaluate nursing education and services in terms of the preparation and leadership prerequisite to good nursing care; and to determine ways of making good nursing care available wherever it is needed.

Day care

Some 200 persons who attended a 1-day conference on day care in Washington, D.C., last June, agreed that the need for day-care services for children grows larger every day but that the means of meeting it lags far behind. The conference was called by two Federal agencies—the Women's Bureau of the Department of Labor and the Children's Bureau of the Department of Health, Education, and Welfare—and Directions Seminar, a group representing nine voluntary organizations. In all, 60 organizations and agencies concerned with the welfare of children sent representatives.

Participants pointed out that a great block to providing sufficient day care to meet the needs is the national ambivalence toward the working mother. On the one hand, her services are welcomed where men are not available for jobs; on the other, many people frown on mothers working outside the home.

The participants agreed that the agencies working to make day care for children available wherever it is needed should take their case to the Nation. "We must spell out the cost and say what we want and why," one participant said in summary.

Other participants recommended the establishment of an agency to coordinate the efforts of all agencies working for day care and to publish a news sheet about activities affecting day care. Others recommended the establishment of an organization in every State to work for day-care facilities.

Anti-delinquency

A strong determination in young people to have some say in planning and executing the programs that affect them was expressed during and after a conference on juvenile delinquency held in Washington, D.C., June 1-2, 1967, at the call of the Secretary of Health, Education, and Welfare, John W. Gardner. In addition to 200 professional persons from the fields of juvenile corrections and youth guidance, the conference participants included 45 teenagers and young adults who are serving as "indigenous workers" or otherwise participating in anti-delinquency or anti-poverty programs.

The focus of the conference was on planning and evaluating programs to combat delinquency with special emphasis on the possibilities of building on lessons learned from the projects supported under the expiring (June 30,

1967) Juvenile Delinquency and Youth Offenses Control Act of 1961.

Secretary Gardner pointed out that \$47 million had gone into those projects to test new methods of combating delinquency—including work training for jobless young people, the revitalization of neighborhoods, the expansion of legal services to the poor, the establishment of multiservice neighborhood centers, and the effort to involve local people in the planning and executing of community programs. Other speakers identified the major contribution of such projects as their emphasis on preplanning, comprehensiveness, and integration of services and on the participation of the consumers of service. Some, however, criticized the projects for an overemphasis on delinquency prevention to the comparative neglect of rehabilitative efforts, a failure to relate to the existing structure of services in a way that would assure continuance, and a lack of built-in methods for evaluation.

Several of the young participants told of their difficulties in getting adults to listen to their suggestions for improving the conditions that spawn delinquency. For example, one young girl told of a neighborhood youth organization in a Brooklyn neighborhood that has worked for desegregating the extracurricular programs in the local high school, State support to help the children of public welfare clients go to summer camp, group homes for dependent adolescents, a desirable site for a new school—all to no avail: "The only thing we succeeded in changing so far is ourselves."

Other young participants spoke of their efforts to help delinquents or potential delinquents work to meet the needs of their communities. Advised one, "Go back and ask the young people of your community 'what do you want so you can stay out of jail?' . . . Talk to the kids, they have something to give, but they can't give it, if you don't listen."

This sense that the adults are not listening prompted the young participants, under the leadership of those in the Washington community action program, to hold a conference of their own, called A Youth Rap, on the day following the delinquency conference. Their agenda contained three items: youth problems, youth programs, and youth federation. There, however, the dis-

discussion was not so much on problems—"We all know what the problems are"—as on the development of a mechanism for exerting influence on "all the youth work being done in this country." As a first step they decided to work for a national conference of young people, organized by young people themselves "with no strings attached."

Child health

Provisional figures on infant mortality for the 12 months that ended April 30, 1967, show a 5-percent drop from the previous 12-month period—from 24.2 per thousand live births to 23.0 per thousand—according to figures from the National Center for Health Statistics, Public Health Service. This is an even greater decrease than the one shown by provisional rates for the 12-month periods which ended April 30, 1965, and April 30, 1966—24.6 and 24.2 respectively—a drop of 2 percent.

Adoption service

The Indian Adoption Project sponsored by the Bureau of Indian Affairs, U.S. Department of the Interior, and the Child Welfare League of America in cooperation with State and local public and voluntary child welfare services placed 67 Indian children in adoptive homes in 1966, the highest number in any one year since the project began in 1958. As of May 15, the project had placed 325 Indian children in adoptive homes, mostly non-Indian. The children ranged in age at time of placement from birth to 11 years, but nearly half were under a year old. The project at present reports having more prospective adoptive parents than children referred for adoption, although it has found through a survey of 90 registered placement agencies that more than 400 Indian children are in need of adoptive homes.

All the Indian children placed through the project have come from Midwestern or Western States, but more than half of the adoptive homes are in the East.

The Midwest Adoption Facilitating Service, a regional agency to help local agencies in seven States and a neighboring province of Canada bring children in need of homes and prospective adoptive parents together anywhere in the region, was recently incorporated

in Minnesota with headquarters in Minneapolis-St. Paul. More than 90 agencies, both local and statewide, took part in setting up the service. The region includes the States of Illinois, Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin and the province of Manitoba.

The new agency grew out of the work of the Indian Adoption Service conducted by the Child Welfare League of America (CWLA) and the Bureau of Indian Affairs, U.S. Department of the Interior, which places Indian children from one region of the country in homes in another if no homes are available where the children live. The service will also assist in the work of CWLA's national adoption exchange.

The service will not place children itself. Rather, it will work to improve the lines of communication between local agencies and their policies and procedures and to modify State laws that make interstate adoption difficult (only Illinois and Wisconsin now have interstate adoption laws). It will stress service for all children, including those called "hard-to-place." A survey of the States involved indicated that over 2,000 children had been waiting more than 90 days for adoption.

Milt Erickson of the Lutheran Social Services, Sioux Falls, S. Dak., has been elected president of the board for the service. His agency has been particularly active in working for an interstate adoption facilitating agency.

Unmarried mothers

The first regional conference on continuing education for pregnant teenage girls took place in Detroit, Mich., May 4-5, under the auspices of the Office of Education, U.S. Department of Health, Education, and Welfare, and the Detroit public school system. The participants included 175 persons—chiefly educators and staff members of health and welfare agencies from both urban and rural areas in Illinois, Indiana, Michigan, Ohio, and Wisconsin. They focused their attention on the school's role in providing continuing education and supportive services for teenage pregnant girls and unwed mothers, the kinds of interdisciplinary and interagency comprehensive programs now available to them in some places, and resources for financing program development and expansion.

Speakers described programs in Chicago, Detroit, Los Angeles, and Washington, D.C., stressing the importance of coordination of health, education, and social services and of interprofessional efforts on behalf of the girls. They also discussed ways of dealing with negative attitudes in the community and pointed to the importance of involving representatives of all segments of the community in getting a program underway. In a discussion of the educational content of a program, courses in nutrition, baby care, and physical and emotional development were recommended to be added to the regular school curriculum.

Education

About 3,000 children who enrolled in kindergartens and first grades this fall are receiving special educational attention through Follow Through projects in 30 school districts in 25 States and the Commonwealth of Puerto Rico. They are the participants in the pilot phase of a new Federal program to help schools sustain the intellectual, social, and physical gains made by disadvantaged children in preschool educational programs, especially the preschool centers established under Project Head Start. The new program is administered by the Office of Education with funds provided by the Office of Economic Opportunity.

Participating schools are using new teaching methods and the services of teaching specialists, teacher aides, psychologists, social workers, and medical specialists to meet whatever needs the children have that affect their ability to get ahead in school. In addition, parents are taking part in Follow Through—as aides or volunteer helpers in the classroom and on field trips and as members of policy advisory committees. Most of the children involved are attending regular classes where they receive special attention. In addition, many schools are providing the children with help in extended day classes—that is, after regular school hours.

According to present plans, Follow Through assistance will eventually be provided to children through the third grade. As experiments, the programs are open to visitors from other school districts, and evaluation reports on them will be sent to other school districts.

The States with Follow Through pro-

FOR CHILDREN OF THE AMERICAS

When the Council of the Organization of American States (OAS) on June 7, 1967, gave final approval to the budget of the Pan American Union (PAU) and certain specialized organizations for the fiscal year ending June 30, 1968, the largest percentage increase authorized for any agency—14.04 percent—was for the Inter-American Children's Institute (IACI) which is celebrating its 40th anniversary this year. (The increase for PAU as a whole was 3.62 percent.) The IACI budget for the 1968 fiscal year is \$139,939, as compared with \$122,706 for 1967.

Recent IACI activities have included three regional seminars to develop standards for family and child welfare in integrated programs of national development; seminars on vocational training of adolescents in Brazil and Venezuela; a nutrition course for training workers to combat malnutrition in Haiti; courses on legislation pertaining

to minors in Bolivia and Paraguay; an advisory service to the national councils for minors in Argentina and Peru; a training course for social workers specializing in child and family welfare, in cooperation with the University of Costa Rica; cooperation with the International Children's Center of Paris in a course for schoolteachers on understanding child behavior, given in Brazil; seminars in Bolivia and the Dominican Republic for officials of civil registry offices, with the objective of improving birth registration and other statistics on children.

IACI has just created a section on mental retardation and will soon hold a seminar on the subject. Another IACI innovation this year will be a series of courses for juvenile court judges and auxiliary court personnel, the first of the kind in Latin America. IACI is also carrying responsibility for the preparation of working documents for the

XIII Pan American Child Congress to be held in Quito, Ecuador, early in 1968. The basic theme of the Congress will be "Population Growth and Its Incidence on Planning for Children and Youth."

The input into IACI activities from cooperating organizations far exceeds IACI's budget. UNICEF contributes fellowships for some of the seminars and training courses; WHO, PAHO, FAO, and the Unitarian-Universalist Service Committee supply experts and funds for nutrition courses and seminars; UNESCO helps with vocational training activities. The services of a small technical staff at IACI's headquarters in Montevideo are supplemented as needed by contracts with experts, thus utilizing and making better known the technical resources already in the American Republics.

—*Elisabeth Shirley Enochs*

grams are California, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New York, North Carolina, Oregon, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, and Wisconsin.

Mental retardation

Students in schools of social work had more opportunity in academic year 1965-66 than ever before to obtain experience in working with mentally retarded children, the American Association on Mental Deficiency found in a survey of mental retardation as a focus in social work education. From a questionnaire sent to the 67 member schools of the Council on Social Work Education, the association received 55 replies, only 16 of which indicated that the school had no students placed in mental retardation programs. The other 39 reported 336 full-time students (or 5.6 percent of their total enrollment) in field units or individual placements in mental retardation programs during

academic year 1965-66. Most of these placements had been set up since 1963.

The survey showed that 32 schools had 57 field units for 264 students using the three basic social work methods; about half were in residential institutions. Seventy-two students were in individual placements—the majority doing casework—in 10 mental retardation programs in 40 agencies, most of them residential institutions and developmental and evaluation clinics. Both types of placements received some Federal support, either from the Vocational Rehabilitation Administration, or the Public Health Service, or the Children's Bureau.

The survey also found that 37 schools had faculty positions for field instructors in mental retardation units; 27 schools had full-time faculty members and 10 had part-time faculty members. Relevant mental retardation content was included in the basic curriculum sequences and research. The content was presented through case teaching methods, formal lectures, assigned readings, audiovisual aids, field observations, and assigned cases in field place-

ments. In 1965-66, 10 schools also conducted short-term training programs in mental retardation such as workshops, seminars, and institutes for faculty members and practitioners.

The schools indicated that they needed teaching material concerning mental retardation, that they had had difficulty recruiting field instructors with experience in social work with the retarded, and that students had difficulty integrating what they were learning in the field with what they were learning in the classroom.

Several State agencies in Iowa and many private social agencies in the State are developing a short-term training project for the foster parents of mentally retarded children. Twelve institutes will be held between October and December of this year. The State agencies involved include the State University of Iowa School of Social Work; the State Department of Social Welfare; the two State institutions for the mentally retarded; the Iowa Welfare Association; and the State mental re-

tardation planning agency, Progressive Action for the Retarded.

To expand and improve foster family care for mentally retarded children, the Minneapolis Association for Retarded Children is recommending that—

- Licensing standards be developed specifically for foster family homes for retarded children.
- The fee structure for such homes be modified.
- Agency-owned foster homes, run by agency personnel, be established.
- Training programs be conducted for the foster parents of mentally retarded children.
- Staffing requirements be established for foster boarding homes that care for more than five children.

These and other recommendations are the results of an inquiry the association made into the use of foster boarding homes for mentally retarded children by the Hennepin County Welfare Department. The association found that the quality of the program was impaired by the manipulation by placement agencies of standards developed for the foster care of normal children; the shortage of available foster homes for mentally retarded children; and the lack of other types of residential facilities for mentally retarded children in the county.

As a result of this study, the Minneapolis Department of Public Welfare is now developing new standards and guidelines for foster group homes caring for mentally retarded as well as "normal" children.

The report of the study, "Foster Boarding Care for Mentally Retarded Children," by Sheldon R. Schneider, is available from the association (2401 West 66th Street, Minneapolis, Minn. 55423).

Mentally retarded children placed in foster families made greater improvements over a 3-year period in all aspects of development, including intelligence, than did children with the same degree of retardation who were placed in an institution, according to the findings of a study recently completed in Kentucky. Conducted by the Kentucky Department of Child Welfare, with the cooperation of the Kentucky Department of Mental Health and support

from the Children's Bureau, the study focused on 30 children placed in foster family homes and 29 placed in a State institution for the retarded.

The two groups were matched at the beginning of the study according to age, sex, IQ, and previous experience in foster care. Both groups of children received training through special education programs during the study period, and both groups made progress in social behavior. Whether or not the children had been diagnosed as functionally or organically retarded bore no significant relation to their degree of intellectual improvement.

As a byproduct, the study demonstrated that foster family homes can be found and sustained for mentally retarded children. In selecting foster parents, the project relied heavily on the social workers' evaluation rather than outside references; foster parents were not excluded because of negative characteristics if they showed counterbalancing kinds of strength; the reports of family physicians on the health instead of the findings of public health clinics, as is usual.

The agency provided the foster parents with casework counseling, individually and in groups, on a more highly concentrated basis than is usually provided foster parents.

The project was directed by Marjorie Wilson. Robert Fishman was its research director.

Foster care

The Iowa Children's Home Society, a voluntary agency in Des Moines, has developed two programs involving foster parents that, it reports, have greatly helped the agency in its work. One offers group consultation to foster parents in place of individual casework; the other is a public relations program through which foster parents interpret the agency's work to civil and religious groups.

Under the first program, about 130 foster mothers and fathers are now assigned to nine consultation groups, which meet at hours convenient to them. During the meetings, conducted by an agency caseworker, the parents discuss their problems as foster parents and their relations with the agency.

The agency also reports that both parents and staff members have accepted the group discussion as a sub-

stitute for individual casework and that it has made the method part of its continuing supportive services for foster parents.

Under the second program, now in its fourth year, a panel of four foster mothers, each caring for a different kind of child, give brief talks about the problems and rewards of giving foster care and how they and the agency work together. If the program is at night, a foster father may join the panel to explain his duties as a foster father. The community relations worker from the agency talks briefly about the agency, the supervisor of foster care moderates the panel, and together with the panel members they answer questions from the floor.

Foster grandparent programs to provide employment for the elderly and the warmth of individual grandparent relationships to neglected, dependent, disturbed, or mentally retarded children have demonstrated great value both for the elderly persons and the children involved, according to a study recently reported by Greenleigh Associates, a nonprofit research organization. The study was made for the Office of Economic Opportunity (OEO) of 10 of the 22 foster grandparent programs being supported by OEO in 1966.

The organization found, on the basis of "professional observations," that 70 percent of the children served showed some physical, social, and emotional improvement and that this improvement in more than 90 percent of the cases could be attributed in part to foster grandparent care. It also found that weaknesses in administration and operation were often offset by the strength of the goals and the design of the programs; and that the programs relied on leadership from OEO and the Administration on Aging, U.S. Department of Health, Education, and Welfare, because they received little local support.

The study was conducted through interviews with members of the sponsoring and host agencies (hospitals and institutions for neglected, dependent, disturbed, or mentally retarded children), site observations, and studies of primary resource material. All of the foster grandparents had been in the program for at least 2 months; all of the children, for at least 2 weeks. Most of the children were about 5 or 6 years old,

though their ages ranged from under 1 to over 13.

Of the 396 children involved, 70 percent were reported to have improved in their behavior or in their health; 56 percent showed improvement in their relationships with others; 52 percent showed improved emotional adjustment; 38 percent showed improvement in physical health and in sleeping and eating habits, and 38 percent, in physical mobility, motor skills, and self-care. The extent of these improvements was found to be similar in all types of institutions, except in an institution for emotionally disturbed teen-

age children, where only 19 percent of the children with foster grandparents seemed to show improvements.

Most of the 269 foster grandparents in the programs studied were women, though both men and women had been sought in recruitment efforts. Most of the elderly persons learned about the program through the newspapers, friends, or social agencies; only a very few, through employment agencies.

The programs studied were in Atlanta, Ga., Denver, Colo., Fort Wayne, Ind., Madison, Wis., Morganton, N.C., Nashville, Tenn., New York, N.Y., Philadelphia, Pa., St. Cloud, Minn., and San

Francisco, Calif.

The study organization recommends that the foster grandparents program be greatly expanded to reach more communities and, through the sponsors, as wide a variety of agencies as possible. Among other recommendations, it also urges that the one-to-one relationship between child and foster grandparent be kept wherever possible and that greater efforts be made to reach potential foster grandparents in low socioeconomic neighborhoods.

(For a description of a foster grandparent program, see *CHILDREN* March-April 1967, pp. 47-52.)

in the journals

School nursing services

The efforts of parents in low socioeconomic areas of Oakland, Calif., to make and keep their children healthy increased appreciably after school nurses in a special demonstration project worked more closely with them than is usual, according to Doris S. Bryan and Thelma S. Cook in the July 1967 issue of the *American Journal of Public Health*. ("Redirection of School Nursing Services in Culturally Deprived Neighborhoods.") The school system found that assigning trained clerical assistants to nurses to handle routine duties such as running the office and keeping records on pupils and assisting in visual screening gave the nurses more time to work with parents, particularly those whose children had special health problems, the authors report. The three nurses' assistants employed for the project received 20 hours of formal inservice training in addition to continuing supervision from the nurses.

The parents of children in three kindergartens received special counseling and parent education services from the nurses; those of children in three others, who did not receive special serv-

ice, were studied for comparison. Contacts with parents were made in the home and in the school.

The authors report that the school system found that an urgent need exists to identify the ways in which the service should be redirected to meet the needs and problems of pupils and parents, the goals the nursing service can attain, and the knowledge and skill needed by nurses in such a program. "Nurses may need . . . to research nursing problems. . . ." and "Redirection may be toward the development of a more highly skilled school nurse practitioner," the authors maintain. The program was supported in part by a research grant from the Children's Bureau.

Grownup child

New Generation is the new name of the *American Child*, bulletin of the National Committee on Employment of Youth, itself a transformation of the National Child Labor Committee. The publication originally appeared over 50 years ago as the *Child Labor Bulletin*.

In its first issue as the *New Generation* (summer 1967), the bulletin focuses attention on possible strategy

for sustaining the war on poverty by presenting a symposium of diverse views on what should be done about the structure and programs of the Office of Economic Opportunity (OEO). The contributors: Richard W. Boone, executive director, Citizens' Crusade Against Poverty; Congressman Charles E. Goodell of New York; Hyman Bookbinder, assistant director, OEO; Kenneth E. Marshall, vice president, Metropolitan Applied Research Center, Inc.; S. M. Müller, program adviser, Ford Foundation.

Emergency parents

An around-the-clock emergency parent service has ended the need for suddenly taking children out of their homes for the Children's Aid and Society for the Prevention of Cruelty to Children in Erie County (Buffalo), N.Y., the agency's executive director Norman W. Paget, reports in the July 1967 issue of *Child Welfare*. ("Emergency Parent—A Protective Service to Children in Crisis.") In the first 11 months of the program, the agency sent emergency parents into 32 homes where 128 children had been left alone, he says. In every case, the emergency parents, sometimes in relays, were able to care for the children until their parents or guardians assumed their parental responsibilities or until the agency could find the right foster homes, he points out.

The agency recruits both men and women and sometimes couples as emer-

gency parents, the author reports. They are on call except while at work for a week at a time and receive a small fee while on call and pay at an hourly rate while in actual service. Each is carefully instructed regarding the duties of emergency parents. This instruction includes describing the limits of these duties—the emergency parent, for instance, does not deal with the parents in any way.

An emergency parent brings a kit of such items as cookware, light bulbs, and insect spray with him when he goes into a home, and, as instructed, he uses an agency staff car equipped with a radio-telephone in case the home has no telephone, as many do not. He also carries an aerosol spray for protection, if needed. However, though parents are

often hostile toward emergency parents when they return home, none has ever been violent, the author reports.

The author points out that while the agency has a homemaker service to serve families in crises such as a mother's illness homemakers are not expected to go into homes in which there is a potentially dangerous situation or in which there is no responsible adult with whom to plan.

Birth weight and blindness

Perinatal factors and low birth weight seem to be associated with blindness in the newborn infants, according to an article in the June 1967 issue of *Public Health Reports* reporting on a study of 553 blind children in

New York State. ("Association of Perinatal Factors With Blindness in Children," by Irving D. Goldberg, Hyman Goldstein, Dana Quade, and Eugene Rogot.)

Of the children studied, a greater proportion than in the general population weighed less than normal at birth—indeed, low birth weight characterized them—and more were of twin birth, the investigators found. They also found a greater proportion than usual of mothers who were at the extremes of the maternal age span (under 20 or over 35), had had complications of pregnancy or labor, were primiparas, or had had stillbirths.

The authors report that the most common type of blindness in the children was from congenital cataracts.

readers' exchange

HAGGERTY: *Comprehensive care*

I want to commend the emphasis in Dr. Haggerty's article on the need to incorporate the concept of comprehensive care into medical training. ["Pediatric Training and the Manpower Problem," by Robert J. Haggerty, M.D., *CHILDREN*, May-June 1967.]

Each person's potential for physical, cognitive, and sociobehavioral health and competence must be nurtured and protected during the formative years in utero and childhood if the citizens of our Nation are ever to attain high-level wellness of body and mind. That we are far from achieving this goal is obvious from the high incidence of physical, intellectual, and behavioral disabilities among the youth of our Nation.

The causes and consequences of many of these disabilities lie as much in the social and behavioral disabilities as in the biologic and physical. Yet, we continue to educate medical students, house officers, and residents as though most of the important maladies of mankind could be cured or prevented by biophysical means alone. This is not

surprising, for it takes a great deal of effort and skill to alter deeply rooted traditions in fields as firmly established as medical education.

It may be advantageous and, perhaps, essential to incorporate the elements of comprehensive health care into the medical curriculum at its outset. Otherwise, students may continue to be so strongly conditioned to think only in biophysical, curative terms that by the time they come to the final stages of residency training they will have little awareness of the significance of social phenomena in medicine and little incentive to invest in a career of comprehensive health care.

This relatively undeveloped segment of medicine is loaded with fascinating and challenging opportunities for imaginative research. The possible topics range from developing methods for the systematic identification and measurement of social and behavioral factors of critical importance in human development, health, and disease to identification of the important variables in the politics, staffing, financing, delivery, and evaluation of comprehensive health

care for segments of the population.

Some medical students might be attracted to university-based careers as investigators and teachers in this field. More important perhaps, many others might be attracted to careers as physicians whose knowledge and skill in the field of comprehensive health care is at least equal to the skill of physicians who are subspecialists in various sharply delimited areas of medicine. Thus physicians trained to provide comprehensive care could, with the support of allied health workers and modern technological devices, take over where the general practitioners of the past have left off, and raise the standards of medical care in our country to new heights.

Thanks to the Children's Bureau and the National Institute of Child Health and Human Development, these exciting possibilities are already being converted into reality, thus providing pediatrics with new opportunities to lead the way in solving some of the Nation's pressing contemporary health problems as it has in the past in controlling the infectious, nutritional, and related diseases that used to kill or maim so many children.

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How Young Children Learn

Behavior of Disturbed Blind Children

Discussion Groups of Adoptive Parents

Mentally Retarded Adolescents



children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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An adopting couple and their "new baby" regard each other with delight and curiosity. The joy of finally receiving a child often obscures the anxiety such couples may feel about the special problems of being adoptive parents. How one agency is helping groups of such new parents help each other face some of the problems they are concerned about is described on pages 223-226.

for those who would help young children build a foundation for later learning, a psychologist describes the

children

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Many doctors and psychologists used to believe that the young infant was so busy feeding and sleeping that not much learning went on; they thought that his development came about almost entirely as a result of his physical maturation. By contrast, recent child development research and observation of both well-stimulated and deprived children provide a basis for far more respect for the spontaneous ways in which the infant learns about himself and about the world and how he can function in it. In one article, I cannot review all the data and theory relevant to infant learning. I will, however, sketch some of the ways in which the relatively unorganized, passive newborn infant becomes the much more organized, curious, competent 2-year-old who copes ingeniously with many problems.

By the time the child is 2, he has learned to adapt his body, his needs, and his wants to the readymade schedules, demands, and opportunities of the world he has also learned the value of protest, of fending off excessive pressures, and of wooing the responses of adults. He continues to master a wide range of motor, cognitive, language, and social skills in the next 3 years before engaging in the formal learning process provided by school.

Discussions of the learning processes in a child have generally taken their departure from, or have been carried on in, the context of learning in school through formal lessons and drill. The thrust toward activity initiated by John Dewey's dynamic idea did not evoke a comprehensive study of the range of spontaneous learning processes that go on in the first years of life in children growing up in stimulating and responsive environments. Piaget's studies of in-

* SPONTANEOUS WAYS * * OF LEARNING * * IN YOUNG CHILDREN *

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LOIS B. MURPHY

infants¹ added to the recognition of the role of certain aspects of sensory-motor and cognitive learning but left many gaps.

The following list of some first steps in learning is based upon my observations of children in different settings and conditions of life in various parts of the world, as well as on results of research.

1. *Learning to use reflex equipment* more efficiently. The newborn infant's effort to perfect his sucking ability points to one of the first types of learning. Some babies are inefficient at first and have to practice to achieve skill, an effort quickly rewarded by more satisfying intake of milk. The improvement of feeding reflexes, including sucking, chomping, and chewing, is paralleled by effective integration of the internal digestive functions.

The Gestalt principle of closure²—the tendency of each functional system to become more orderly as a result of growth or practice, or both—is involved at all stages. The pleasure principle is probably also involved insofar as improved functioning eliminates the pain of frustration, delay, conflict, and ineptitude and results in "function pleasure"—pleasure in the well-functioning activity itself. The achievement of smooth and satisfying organic functioning provides basic conditions helpful to orderly cognitive learning.³ This probably involves the equilibration processes discussed by Piaget.¹

2. *Passive looking, listening.* Young infants can often be observed within the first days of life staring, listening, attending to a sight (bright light) or sound that impinges upon their senses. They may not ac-

tively reach out for stimulation until they have experienced some satisfaction from their first passive learning.

The first step is orientation.⁴ Just as sucking and other oral patterns have to be refined, so does the coordination of external and internal eye muscles have to be improved with practice. But the baby begins to stare and to look almost from birth.⁵ As a result, he learns to connect things seen together and, later, to compare and test.

3. *Learning to actively select and turn toward stimuli* follows upon reflex orientation. We can see this in some very young infants whose mothers respond to their indications of restless "wanting to see more." A 4-week-old infant in the group studied by Escalona and Leitch "couldn't be held lying down."⁶ I, too, have held babies who were not relaxed until held in a position from which they could see around.

The baby's turning toward new patterns or toward particular colors or faces, well documented in research,^{7,8} is a step beyond passive looking at whatever is there. We often see very young babies in their mother's or father's arms visually exploring a strange environment. I have seen older babies, of 8 months to a year, twist and turn to maximize their visual range as they looked ahead, behind, to each side, and up and down. This visual searching probably leaves traces, or engrams, which in turn lead to fresh movements of the eyes as if to keep on catching still more. Berlyne⁹ and others have discussed the intrinsic need for *fresh* stimulation, a need flagrantly disregarded in much institutional care.

People are observed more vigorously and often

than things by many babies, probably because some people provide gratification of their needs and also because faces and bodies are complex rather than simple, are constantly moving, and provide multi-sensory rather than unisensory stimulation. Pleasure derived from colors, shapes, and voices is also behind the baby's people-watching.

4. *Exploration of a wider environment* as the baby grows older and is able to move around, "casing the joint" and peering into things, is a still more active way in which infants and small children successively "find out about" the world and its possibilities. This very active, self-initiated effort to learn about everything around them can be observed in infants and children growing up in interesting and varied environments. But it is usually lacking in children growing up in barren, dull environments. The baby has to learn that active attempts to learn are rewarding.

5. *Cognitive mapmaking* as described by Tolman¹⁰ is another aspect of learning in infants. The baby uses the results of his active exploring, organizes them, and holds onto them as an aid in orientating himself to the world, managing it, and getting around in it. The creeping baby soon learns that he can find mother in the kitchen even though he does not know the word for kitchen.

The baby learns by listening as well as through visual-motor and tactual activities. One 4-month-old baby I knew learned to recognize the sound of her father's footsteps and bounced in her carriage vigorously when she heard him coming. Some infants learn to recognize musical pieces and have favorites before they are a year old. Babies in our longitudinal research sample at the Menninger Foundation in Topeka, Kans., showed wide individual differences in their responses to different kinds of sounds. Some babies seem to make an "auditory map" along with a visual map of their surroundings—that is, they learn to associate certain sounds with places and actions.

6. *Combining*, bringing two things together accidentally or intentionally, helps the child to *discover what happens*—what sound results, for instance, if he bangs a wooden spoon against his crib. This results in the baby's "learning to make something happen," as Thorndike put it long ago, tying it in with the baby's "pleasure in being a cause."¹¹ Today we think of the dynamics of elementary feedback and the enhancement of self-awareness and of power as implied in Charlotte Bühler's observation of the

"triumphierender Blick" of the nearly 1-year-old baby.¹²

Perhaps taking apart or opening up is also a form of experimenting to see what can be done with things. This type of activity begins with some babies at about the same time as combining. Pulling at things and tearing up paper, wool, or cotton batting contribute to the baby's learning about textures and the variously yielding or resistant qualities of materials.

7. *Organizing* all of the oral, auditory, visual, tactual, and visual-motor processes of learning goes on at different levels of complexity. Bits of raw stimuli become familiar and are organized into meaningful, complex units of experience and built into transactional structures, that is, internal patterns that become automatically available in a relevant situation. The overall pattern of such structures may be seen as the infant's "primary adaptational style."¹³ One baby's style is very different from that of another. But these structures are not static and fixed. As the baby continues to learn more, he modifies his cognitive map, his coping skill, his self-image, and his relation with others—and this modification increasingly contributes to how and what he learns. More efficient structures displace the early, less inefficient ones.

We can see from the way a child as young as 2 or 3 years spontaneously organizes toys presented to him in a random fashion that the tendency to give structure to scattered materials is part of the human package of potentials¹⁴ and gives the child what Berlyne calls "epistemic" curiosity.⁹ The child's ability to structure depends on the degree of his previous assimilation of and accommodation to many kinds of forms and structures in the environment.

8. *Mastery of the body*, as in rolling over or holding up the head, exemplifies the same principles as the improvement of the functional reflexes, but includes an integrative quality not present in the reflexes. Body mastery is involved in the development of "ego functioning" in the psychoanalytic sense—that is perfecting the motor skill is paralleled by, or followed by, use of the skill in an ego-controlled, or purposeful, bodily activity.

Learning to make oneself comfortable may take place at the same time. In the Escalona-Leitch sample, a 1-month-old infant wiggled herself to a cozy corner of her crib and stayed there.⁶ Wiggling and turning the body around a little can often be observed in an infant before he is able to turn over from back to front or vice versa. By the age of 3 or

4 months, babies have learned to stretch, push, turn, or otherwise adjust their bodies when held. Turning away from unpleasant stimuli by turning the face or body away may be seen in even younger infants. This is one early way of adapting to the world.

9. *Learning more complex body and motor skills* continues steadily from early infancy. Learning to pull oneself up when somebody is holding one's hands, to turn over, sit up, creep, stand, walk holding on, and walk alone are steps that occur with practice as muscles achieve the necessary degree of coordination.

Each level of body management brings new learning possibilities. The baby may learn to cooperate in various kinds of gymnastic play with his body, initiated by his mother or father, and may bounce to rhythm when sung to. Such activities may involve learning to balance in order to maintain equilibrium while participating. For example, a 4-month-old baby I knew spontaneously learned to spread out her arms and legs to balance herself while her father held her aloft, supporting her abdomen on the palm of his hand.

Increasingly, the baby is able to use his improved motor skills to cope with restlessness and boredom or to satisfy his expanding interests. He may learn that, by himself, he can slide down his high chair and slip free of it or climb out of his crib. He may learn to creep downstairs backward before he can manage to go down forward.

All of these forms of body-learning not only develop increased flexibility in the baby, they also prepare the baby for learning more complex skills as he grows older.

10. *The development of curiosity.* Progress through the early stages of sensory and motor learning develops resources that contribute to further learning. Growing up in a richly rewarding, varied environment leads to an interest in further scanning and exploring. This is made possible by the extension of the range of motor skills that enable the baby to get into everything from the floor-level kitchen cupboards to the bottom drawers of his mother's dresser. Thus, he develops curiosity from the gratifying discoveries made in his widening world. The child deprived of stimulation usually does not show such curiosity.

We can say with Bateson¹⁵ that through all the first phases of learning the adequately stimulated baby accomplishes important secondary or "deutero-learning"—that is, he learns to learn, learns that it



Following a normal developmental pattern, this happy infant has learned to select and turn toward stimuli. Apparently, the activities of the photographer interested him more than the toy.

is fun, interesting, and exciting to learn. The preschool children in our Topeka sample of middle-class children from at least moderately rewarding homes typically explored each new situation with eagerness, curiosity, and interest. In contrast, the children from disadvantaged homes did not do such exploring until after many months of encouragement and stimulation. Even then, they did not ask questions with the same degree of curiosity as the middle-class children. When the deprived children began to ask "why" questions, they asked chiefly about the teachers they had learned to trust, not about the world at large.

Thus, *learning to want to learn*, to respond to new situations with interest rather than passively or inertly or fearfully, is another aspect of the early development of learning. This includes *learning to practice*, which may actually begin when the infant first "works at" improving his sucking and, later, other motor patterns. But the baby's spontaneous practicing becomes more conspicuous as he repeats syllables or assiduously struggles to master a motor skill.

11. *Learning from pain.* Many observers, including the mothers of children in our Topeka sample, have reported instances of very young children learning from pain. The child learns not to put his hand on a hot radiator after one painful trial. The cat scratches and *maybe* the child does not pull his tail

again. Levy,¹⁶ in a study of 2,000 infants given a series of inoculations, found that after the first inoculation infants under 6 months cried at the total situation, including the office and the doctor in a white coat; the youngest infant who cried only at the approach of the needle was 6 months old. This implies development of the ability to differentiate a specific pain-producing stimulus from the whole context in which the pain was experienced. However, *learning to avoid* unpleasant immediate stimuli begins almost from birth.

While the baby searches and reaches out for stimulation, he also has to protect himself from overstimulation. Benjamin¹⁷ has observed that the baby between 4 and 8 weeks old becomes more sensitive to visual and other kinds of stimuli. While the perceptive mother helps protect him, he also learns to protect himself by various methods of avoidance or protest. Infants 4 weeks old or younger have been observed to shut their eyes or turn their heads away from bright lights.¹⁸

12. *Learning what to enjoy* is similar to learning from pain. The youngest baby spits out bitter tastes and accepts sweet tastes. By the age of 4 or 5 months he smiles or reaches for pleasurable stimuli. At this age the babies in our Topeka sample had already developed preferences among foods, colors, toys, and other objects. Babies have subtly different preferences—some of them enjoy a rapid, vigorous rhythm while others prefer a slower, gentler one. Some enjoy longer and more intensive tactile stimulation than others can tolerate. As they grow, they acquire new tastes, that is, they learn to like things they did not originally like.

13. *Learning to evoke rewards* is related to learning to love. When a baby repeats such syllables as "da-da" or "ma-ma," he gets delighted smiles and hugs from responsive adults. Learning to evoke pleasant experiences is similar. At 20 weeks, one of the babies in our sample would bounce or rock on his mother's lap in order to stimulate her to bounce him in response. The mother's gratifying response in such a situation is part of the conditioning that goes on through much of early childhood.

Another infant at the age of 8 months would make a blowing sound with his mouth in order to get an adult to put a record on the phonograph; he was accustomed to seeing his mother blow the dust off a record before playing it. The baby always smiled in pleasure at the music or moved rhythmically.

The baby's social learning does not begin with his

smile, but is accelerated by it, since the smile provides stimulating feedback from the mother and other persons. While the smile itself is an "innate" response released by sensory stimuli of various kinds⁶ and by seeing the smile of another person or simply his eyes and forehead, the baby has to learn what his smile can do for him and how it brings forth attention and satisfying stimulation.

Loving is a complex outcome of much learning. Out of the early tactile and kinaesthetic experiences of being cuddled and exchanging smiles, the baby learns to love and be loved.¹⁹ This mutual process gives rise to the learning of many patterns of expression in a more complex manner than the earliest conditioned responses are acquired.

14. *Trial-and-error approaches* to learning grow out of the child's accumulation of sensory learning, development of motor skills, evoked curiosity, and pleasure in making things happen. For example, a year-old baby will try this way and that to fit a cap onto a bottle or to put something into something else.

15. *Learning through contagion* has been noted in babies by both Escalona²⁰ and Anna Freud.²¹ This tendency is related to a baby's anxious, tense response to a tense mother. In such situations, the baby may be learning through skin and muscle sensations as well as from facial expressions. Long ago Preyer reported on a very young baby's *ability to imitate* a protruding tongue although he cannot see his own tongue.²² This type of learning, still an obscure process, may be related to the process of learning by contagion.

16. *Learning by participation* takes place when the mother plays with the child, for example, showing a 9-month-old baby how to play pat-a-cake by holding and moving his hands. All of the early mutual body adjustments between mother and infant have prepared the way for this. Older children also learn in this way. I have seen tiny newcomers to Israel helped at an induction center to learn to feel at home, to develop a sense of belonging, and to acquire some of the language through participating in singing and marching games, with adults taking them by the hand and leading them through the movements. Many children who find it hard to enter a new situation can be helped in this way.

17. *Learning by imitation* involves the use of skill in observation and interest in and responsiveness to new activities. A simple form is parroting. This type of response shows the essential humanness of the

learning processes since it involves not only sensory, motor, and perceptual learning, but also, probably, as Piaget has noted, the assimilation of the mother's actions and accommodation to them.¹

18. *Learning by identification* is a more comprehensive and deeper kind of learning. It includes imitation, but it also includes a feeling with, an adoption of role, a fantasy of being the mother or father, and serves as rehearsal for taking on the real role in later life. Identification requires the capacity for organizing sequences. It was reflected in the behavior sequences of an 18-month-old toddler I observed who busied herself wrapping up her "baby" (doll), putting it into bed, covering it up, and saying "Night-night," while her mother cared for the new baby in an adjoining room.

19. *Learning to cope with frustration* usually involves some combination of *learning to delay gratification* until a later time, *learning to accept substitutes* for the specific object desired, and *learning to shift interests*. Some infants and young children learn to deal with frustration more easily than others.

Even when only a few weeks old, some infants who at first frown, cry, or turn away when a bottle is offered them instead of the breast finally learn to accept it. In our Topeka sample, most mothers consciously tried to help their babies *learn to adapt* to the nuisances of infant life by tempering the discomfort with soothing pats or cuddling.

In helping babies *learn to "get used to" new situations* and experiences, mothers also use conditioning methods. The alert mother helps the baby by providing opportunities to associate the new experience with familiar types of gratification, or by presenting the thing that is new to the baby, such as an unfamiliar food, in small amounts until he learns to like it. When a child responded to a rabbit with fear, Mary C. Jones²³ gradually reconditioned his response. In a series of stages, she brought the rabbit into the room where the child was happily eating, until he finally learned to accept it.

20. *Learning to be comforted*, to accept soothing from others, may depend on the skill of the mothering person in finding the soothing technique that is most relaxing to the infant. (Some babies may be soothed by jouncing or patting, but others will only become more annoyed by such treatment.) A corollary to this is the *expectation* that one can be comforted—the baby learns that hurts need not last very

long and that he can evoke comfort from someone else.

21. *Learning to amuse oneself* is not the same as the simple process of learning to make something happen. It depends rather on the "deutero-learning" that when one is alone one can still engage in some satisfying activities. Finding this out, the baby then learns to initiate such activities.

22. *Learning to fear*. The capacity to be afraid and anxious is inborn, but the baby learns *what* to fear in the same way he learns to avoid pain. He may even *learn how afraid he must be in order to evoke support* from someone.

Fear of strangeness may be innate; strong negative reactions to strangers have been seen even in chickens.²⁴ But the fact that different babies show fear of strangeness and strangers at such varying ages as 8 weeks and 8 months shows that fear of the stranger is also related to how much the baby has learned to differentiate between the familiar and the strange and also whether he has previously experienced discomfort with strangers (in contrast with the comfort he associates with mother).¹³

23. *Learning anger*. The newborn's screams of hunger and pain sound so angry that we may think of anger as the first strong emotion expressed. It is evident before any expression of pleasure. But the baby learns rapidly what his angry protests will do for him. They are at first vocal, then physical: He learns to slap or hit, to stiffen or rear back, and to combine various other bodily behavior patterns in angry resistance. Breath-holding, head-banging, smearing feces, and other types of behavior may be included in the range of resources he learns to use in order to get attention or to make the adult stop doing something he finds unpleasant.

Any of these behavior patterns may arise spontaneously at first and then be quickly reinforced by

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the consequences, including the sensations they give the baby himself. (Some babies are careful not to hurt themselves when banging their heads against the wall or floor.) Pathological uses of such behavior patterns sometimes develop, especially in neglected babies, arising from a combination of self-gratification and masochistic enjoyment of pain. More normally, a baby learns to use such behavior as an effective method of *discharging* angry feelings and "getting over it fast."

24. *Learning to trust the world*, as derived from the basic relationship of mother and child, has been emphasized by Erikson.²⁵ The balance of trust and distrust of the world is also a global form of "deutero-learning" growing out of everything the baby has previously learned. The predominantly distrustful child will later learn chiefly those things that relate to danger and are perceived by him through vigilant, anxious, rather than open, eager observation.

25. *Learning to unlearn*, to give up old patterns, is a major learning process of infancy and early childhood. Giving up the bottle as new feeding methods are mastered, giving up creeping as one learns to walk, giving up babbling as one learns to talk, and giving up crying as one learns to express wants verbally are only a few of the important examples of learning to outgrow early forms of behavior. Sometimes, as when the child gives up creeping for walking, the principle of dominance supported by improved efficiency makes the giving-up easy; sometimes, as with weaning, the giving-up process has to be assisted by the mother using the pleasure and pain technique.

Outgrowing babyishness brings new rewards, among which is an expanded horizon for learning; for satisfying the sensory, motor, and manipulative urges, curiosity, eagerness for mastering the environment, and the wish for autonomy.

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PATTERNS OF CHANGE

in DISTURBED BLIND CHILDREN

in RESIDENTIAL TREATMENT

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About 4 years ago, the authors of this paper, charged with the task of rehabilitating an institutionalized group of 20 severely disturbed blind children, ranging in age from 6 to 12 years, began to formulate and test hypotheses about the factors impeding the development of these children and the methods by which they could be psychologically rehabilitated. We assumed that because of their blindness the children had from infancy been deprived of the stimuli necessary for development and the experiences that lead to a mutually satisfying mother-child relationship and that such deprivation had led to the deviations we observed in all aspects of ego functioning—in intellectual achievement, emotional stability, physical competence, ability to engage in satisfying interpersonal relationships. In some instances, the deviations had already been aggravated by congenital defects affecting the central nervous system.

On the basis of this hypothesis, we assumed that experiences could now be provided that, if appropriately matched to the developmental levels of the child, would provide him with more effective methods of adaptation than he had previously adopted and would thus facilitate more normal development. We, therefore, have concentrated our efforts on carrying out an educational therapeutic program that would provide such experiences and will here describe some of the changes that have taken place in the children. The institution that has been involved is the Children's Division of the Syracuse Psychiatric Hospital, located in Fairmount, a suburb of Syracuse, N.Y. Thus far, all the children in this

residential unit have been blind children, though plans are now underway to accept other children. The staff has consisted of a child psychiatrist, a clinical child psychologist, a supervising psychiatric nurse, a staff nurse, a recreation director, four special education teachers, a psychiatric social worker, an occupational therapist, and several previously untrained child-care workers.

The children

The children were admitted to the program over a 2-year period, beginning 4½ years ago. Thus, we have known all of them for more than 2 years and many of them for more than 4. When admitted most of them appeared to be functioning at a severely retarded level; in fact, the parents of several of them had been told they *were* retarded. However, after the children had been with us for some time and had developed trust in the staff, manifestations of their intellectual capacity became evident and we realized that most of them were of at least average intelligence and many were very bright. Because of technical difficulties, previous testing of them had been misleading.

The impression of severe retardation was augmented by several behavior patterns, some of which seem to be characteristic of blind children. There was a great deal of rhythmic rocking, head rolling, body rolling, head banging, and whirling. Fingers or fists were constantly being stuck in eyes. Language was almost always used in private ways incomprehensible to members of the staff or other persons. There was

meaningless parroting of television commercials, phonograph records, or statements the children had heard people make. Pronouns, when used, were often reversed; "I" was never used. Mutism with occasional guttural sounds was frequent. Thus, the children isolated themselves from both peers and adult staff.

Among other characteristics were suspicion, hostility, fright, withdrawal, and extreme negativism. The most ordinary experiences would be regarded as terrifying. Though many of the children had learned the necessary skills for self-help, they retreated into helpless dependency.

Very few of the children had developed any skill in moving about; most of them released their motor energy while remaining almost in the same spot by using rhythmic or whirling movements. Some tended to overbreathe when excited, and some vented their feelings through screaming, scratching, and biting. Two or three retained feces; one had developed an enlarged colon as a result.

None of the children had had any successful school experiences. Two or three had learned a little braille, but none had been able to profit in any consistent manner from a planned and sequential educational process. Those who had been to school had been dropped out and the others had either remained at home or had been sent to institutions for the retarded or mentally ill.

When we encountered the children, their interest in the external world and in learning seemed nonexistent. Their attention span was short, and their frustration tolerance was extremely low.

The program

The heart of the program lay in an expectation that each staff member would show the same respect to each child regardless of his individual developmental level; would provide the child with interpersonal and other kinds of experiences to help guide him to the next step in development; and would patiently allow him to achieve that step at a speed consistent with his specific needs.

Such impartial respect was not easy to achieve. Many of the children developed subtle and skillful methods of attracting the staff's attention not only to meet their own needs but also to find out whether they could render staff members less effective in treating some children than others. Other children, because of their silence and self-effacement, made it easy for the staff to forget about them. Nevertheless, all the children were enormously sensitive to any degree

of difference in a staff member's attitudes toward particular children. They obviously felt far more secure when they knew appropriate care was being provided equally for all. In spite of the difficulties, the staff did achieve a high degree of impartial respect, and this, more than any other element in the program, may have helped the children realize that they were free to experiment with many forms of behavior in search for paths to identity and development.

The program has also placed emphasis on continuing the children's relationship with their parents, largely through weekend visiting. Most of the children have gone home almost every weekend since their admission. This has meant that they have continuously had to adapt to the contrasting personal environments of home and hospital. The psychiatric nurse, the psychiatrist, and the psychiatric social worker have also maintained contacts with the parents, usually informally but occasionally in formal appointments, at their own or the parents' request. Some changes in attitude have occurred in many of the parents, especially as they have come to recognize that their children are not retarded. But, on the whole, the parents have not altered their basic rejection of the children and continue to wish for a child that is "normal" in every respect.

Some of the children have learned to perceive their parents' rejection of them without having to give up an emerging sense of identity in favor of utter compliance and without having to accept the idea that they are peculiar and incompetent. With the help of the psychiatrist and selected staff members, they have been working through feelings of extreme anger toward their parents, anxiety about such anger, and an increasing sense of separation from them accompanied by intense grief. A few have emerged from this emotional struggle with greater tolerance for their parents and greater confidence in their ability to adapt to them. None of the children, however, has actually completed this working-through process.

One aspect of the program that has helped to decrease anxiety in the children has been the provision by the psychiatrist of all medical care and supervision, except in instances of severe illness or injury.

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All the children at first were terrified of even painless medical procedures. As they became familiar with the psychiatrist through frequent contacts with him, they developed enough trust in him to accept, and in some instances even to participate actively in, medical procedures, including the physical examinations carried out by him. This led to some children learning to cooperate readily with the dentist and with the pediatrician when he is called in.

Regression and progress

In spite of careful preadmission preparation, the children always reacted to admission with a great deal of separation anxiety and grief, which each revealed in his own way. Some children on admission wept quietly, withdrew completely, behaved frantically, or talked constantly about gratifying experiences they had once had. None attempted to cling to staff members for comfort.

Members of the staff could do little at this time other than to tell the children about the care they would receive and when they could next be with their parents and to help them with the daily tasks of bathing, washing, toileting, dressing, and eating. No physical examinations were attempted.

After admission (shortly afterward or long afterward) some regression occurred in most of the children and was accepted by the staff. Many of the children gave up skills they had painfully acquired over years of home training. They ate with their fingers, refused to eat altogether, or demanded special foods. They refused to wash, bathe, or dress themselves, although nearly all had performed these tasks with skill before admission. Many of them began wetting and soiling themselves, although they had not been doing this previously.

Psychological testing was, of course, impossible in his period, as was group or individual psychotherapy in the usual sense. As in the admission period, the attempt to establish meaningful relationships was made through giving the children practical help in the daily tasks of living such as cutting up their food, serving and feeding them, bathing them, cleaning up their vomitus and feces, and making their beds. All staff members, professional and nonprofessional, participated in these tasks.

During their regressed phase, most of the children began exploring the environment, primarily by touching and listening. A child who seemed completely out of contact with reality, for example, would be found whispering something he had heard some-

body say in person or on the radio or phonograph, minutes, hours, or days before. Some children would mimic staff members or other children without interacting with them in any other way. Some clapped, stamped, whistled, or clucked as they went about orienting themselves by sound or touch to their environment.

Very gradually, a few children began to evince an interest in having mutual relationships with people. Others only seemed to be "with" people; they initiated contacts, were compliant, and talked relevantly but their interaction was superficial and manipulative. Usually, a relationship was begun by a staff member making himself available to a child either to help him with a task such as dressing or to give him an experience such as going for a walk, swinging, jumping on the trampoline, or playing a record. The child would at first simply move closer, touch the adult, or talk in obscure phrases. Some children valiantly tried to comply with the adult's wish even when they did not want to participate in the suggested activity. Others responded negatively, obviously expecting reproach and punishment.

Some children who seemed to be relating with adults best because they knew how to talk intelligibly achieved the least genuine relationships. As time passed, they failed to progress past the stage of asking and reasking questions or talking about irrelevant and meaningless topics. Other children who at first seemed much less ready for human contact because they proceeded so cautiously eventually formed meaningful relationships both with staff members and other children.

After breaking through their isolation to make a contact with another person, the children would begin experimenting with others—at first, usually, only adults. They would gradually learn to distinguish between the roles of the various staff members and to relate differently to different persons, dependently with some and independently or even negatively with others. As they became more confident, they would usually attempt to manipulate adults by conversation, compliance, defiance, or negativism, and often mimicked the admonitions and reproaches they had received at home and thereby revealed much about their previous relationships. From such responses, the staff could begin to recognize the carefully concealed personalities of the children and their highly individual ways of looking at life and people.

At some time during the course of this experimenting with relationships, each child would begin to pay attention to other children and to the sur-

rounding environment. No child remained completely aloof and isolated; all formed relationships of some kind with several persons. But these relationships were developed by some children more rapidly than by others and were constantly changing. The children would identify first with one adult and then with another as though they were attempting to work out different ways of feeling, thinking, and being as they made their way toward less distorted conceptions of themselves. A whispered word, an interrupted gesture, a slight change in the verbal pattern heralded major changes to come. As the children grew self-confident because of many staff-planned experiences of success, they began to develop genuine respect for each other and to form strong friendships. Eventually they came to know each other very well and in some cases far better than the staff knew them. They were extraordinarily aware of each other's feelings and actions. They were tolerant of each other's behavior and often perceived the meaning behind it. Sometimes even when a child was attacked by another and his feelings deeply wounded, he could be objective about why the other child had behaved as he had. Gradually some children revealed themselves as followers and others as leaders; some as passive and submissive and others as active and dominating; some as quiet and others as noisy; some as given to intellectuality and others as given to intuitive responses; some as humorless and others as full of humor.

The struggle for a sense of identity met with obstacles, too. For example, Jane, a severely disorganized psychotic child, was made intensely anxious by an even more disorganized child, Mary Ann, and would immediately leave the room when she became aware that Mary Ann had entered. Whenever Mary Ann would scream, stamp, and bite herself, Jane would become panicky and burst into tears.

Use of language

The children's growing ability to relate to people and to identify their own individuality was revealed in their changing use of language. At first nearly all the children spoke to staff members only in meaningless phrases; they used language not to communicate but to conceal. But gradually, as they learned that the staff members could be trusted and were trying to understand them, many of the children learned to respond with some relevance and intelligibility, with less secretiveness, and with a more appropriate use of pronouns.

In their increasing interactions with each other, the children used language to mimic, ridicule, tease, manipulate, or simply to play with a kind of code that they all seemed to understand and to enjoy. Perhaps what they enjoyed most was the knowledge that *they* knew what they were talking about but the staff member in attendance did not.

The children's use of language has provided an instrument for measuring changes in self-concept and levels of anxiety. When we first knew them, most of the children referred to themselves by name, or by the pronouns "he" or "she" or "you." Some have gradually begun to say "I," although even those who have improved most still have only a tenuous hold on this self-identifying pronoun.

Reduced anxiety

As the children developed relationships with staff members and with other children, their anxiety notably decreased. They showed fewer signs of panic when introduced to new experiences or to strangers. Their reactions became less extreme and more controlled in expression. They began to exhibit defense mechanisms against anxiety. Perhaps the most important influence in reducing anxiety was their certainty that they would be dealt with candidly by the staff. Some children, in an effort to master their anxiety, began to talk constantly about situations that provoked anxiety in them. Some, when in anxiety-provoking situations, would talk about previous situations that had been comforting to them.

As the children's anxiety decreased, they reacted with less negativism, accepted limitations on their behavior, tolerated frustration better, and began voluntarily to explore the space around them. Since the unit is in an open building situated on spacious grounds and the children have been free to go in and out, opportunities for exploration have been extensive. A few of the children have explored the whole area thoroughly, and most of them have become well enough acquainted with it to be able to get about in it efficiently. They often go outside to seek privacy and so reduce the anxiety generated by increasing contacts with others.

Thus it is obvious that another respect in which the children have changed is mobility. Apparently anxiety and fear of aggression had as much to do with the extremely constricted mobility they had shown on admission as did fear of injury or disorientation in space. While the whirling, rocking, and rhythmic movements have persisted in most of the

children, the frequency and intensity of this type of behavior have greatly decreased and the children's ability to move in a relaxed, coordinated fashion in play, exploration, or aggression has noticeably improved.

Other children have learned to roller skate and to dance. However, the motor experience in which the children seem to feel most free is swimming. They have been taken regularly to a nearby indoor pool in the winter and to a lake in the summer. Many of them rapidly lost all fear of the water and especially seemed to enjoy the three dimensional freedom of underwater swimming. However, they responded negatively to attempts to *teach* them to swim; they wanted to learn to manage the watery environment on their own or at least to control what the adults did with them in the water. Only after many months of exploring to find out what they could do by themselves were any children ready to learn to swim in the usual way.

Changes in aggression

As the children's anxiety decreased, so did their fear of aggression, their own and others'. When they first came to the unit, most of the children made attacks only on themselves—biting their arms, violently slapping their faces, or banging their heads against objects. At the same time, they were very much afraid of being attacked by someone else and usually would move rapidly away if anyone at all touched them. After a while, they began tentatively to attack objects—a toy or something metal that made lots of noise, like a window screen. Gradually they became destructive of things and eventually they began directing their aggression against staff members by scratching, pinching, biting, kicking, and hitting them. While the staff members often protected themselves by moving quickly out of range, they responded with equanimity, thus helping the children to feel safer in directing their aggression outward.

As the children developed relationships with other children, they learned to assert themselves aggressively with each other. They still try to control the anxiety they feel about their own aggressive actions by finding reasons why the other child "deserved it" or by setting up rules under which aggression might be expressed. Often the whole thing is turned into a game in which a child, known by the others to be very angry but completely incapable of showing it and unwilling to defend himself, is playfully attacked. Sometimes, rather than engaging in combat

himself, a child will direct others to tease or attack the object of his anger. The children talk a lot about aggression and whether or not people who engage in it are "good" or "bad." At times a child will attempt to keep his feelings of aggression from getting out of his control by asking permission to pull someone's hair or bite him.

After a while the children's primitive, highly aggressive outbreaks began to decrease. They were replaced by more ritualized and controlled forms of aggression in some children and by a redirecting of energies into environmental exploration, program activities, and learning in others.

Limits and demands

As these developments have taken place, the staff has attempted to keep pace with the developmental needs of the children, providing new experiences of all kinds—physical, emotional, social, and intellectual—in an increasingly more controlled and directed program. For example, the children's participation in making or listening to music has increasingly been directed to specific ends.

Most of the children, before coming to the unit, had had extensive experience with record players. Some had had piano lessons and had learned to play well. However, the children's musical experiences often had been associated with some unpleasantness—being pacified or isolated or having an ability exploited to the neglect of important needs.

As the children began to show more interest in music, the staff began to impose limits both on phonograph playing and the use of the pianos. The music teacher made advance schedules for playing records or tapes and selected those to be played, exposing the children to a wide variety of music. The children now listen intently during the music period and are often heard spontaneously humming tunes from the music that has been presented to them. They have completely accepted the restrictions placed on their handling of the musical equipment.

As specific children indicated they were ready to learn, the teacher scheduled formal music lessons and practice periods for them. However, some of the children who asked for music lessons were denied this privilege because of indications that they would then have given up all efforts to develop in other ways, or because they were interested not in learning but in competing with other children.

The music teacher, like the rest of the staff, has been heavily involved in all aspects of the children's

development. He helps them make their beds, dress, and clean their rooms, and he goes on expeditions with them. The children have thus learned of his interest in their development as a whole and have acquired such confidence in him that they can accept teaching from him without having all of their negativism immediately aroused.

As the children have moved toward greater relatedness, an increasing complexity of performance has been demanded of them. The staff has shown its respect for their capacity to grow by insisting that those who are able to do so make their own beds, put away their own clothes, dress themselves, use table utensils, and assume such chores as setting the table, carrying their own dishes out to the kitchen, helping to serve food, and washing dishes. Such demands have not been made on all children simultaneously but only on specific children as they have shown readiness for assuming some responsibilities. Of course, there has been much resistance on the part of the children to such demands, but as they have carried out the tasks involved, their respect for themselves and for each other has appreciably increased. All the children are now actively participating to some degree in their own physical care, and a few are helping in the care of the more dependent ones.

Presently, about half of the original group are participating effectively in an educational curriculum including French, English, biology, history, braille, and music appreciation. Four are learning music theory in addition.

Contribution of the staff

The most important ingredient in bringing about the changes noted has been the willingness of staff members to work as a team, to see beyond their own specific professional identities to the ultimate importance of building in each child a capacity to trust and to relate to other people. This has meant that

everybody on the staff has had to take part in meeting the child's particular needs of the moment, whether this involved cleaning up a mess, bathing, dressing, or feeding. It was only through giving the children such elemental forms of patient attention that they could help the children learn to trust.

At first, the staff had no comprehension of this fact and could not function as an integrated team. There was little agreement as to how the children should be treated or about the nature of their problems. There was much confusion and intrastaff hostility, particularly in relation to problems of professional identity and theories of child care. Some staff members left, unable to adapt at all to the team approach. Others adapted sufficiently for the staff to be gradually welded into a smoothly coordinated therapeutic team, adjusting flexibly to the changing developmental levels of the children, picking up and acting on cues from each other, and being mutually supportive in trying times. There have, of course, been some weak links, for to achieve an ideal coordination in working with such children is a difficult task.

We have found, however, that when a central core of professional persons retains responsibility for coordination and planning in relation to each child, the children can learn to adapt to those staff members who find themselves temporarily or permanently at odds with the team's generally accepting and encouraging approach. We have also found that the staff members who can be noncoercive and at the same time can encourage children to have new experiences are those who best avoid feelings of depression and inadequacy in themselves and are those most trusted by the children.

In the near future, the unit is to become the Fairmount Institute of the Division of Child Psychiatry of the State University of New York, Upstate Medical Center, Syracuse. It will be greatly expanded and will include sighted as well as blind children in both residential and day treatment.

. . . Increasing specialization of professions and agencies calls for increased skills and increased facilities in the coordination of services, and this *coordination* is dependent both on a willingness to *cooperate* and an ability to *communicate*. Here lies an ever-present challenge for all of us working on behalf of the world's children.

Gunnar Dybwad, director, Mental Retardation Project, International Union for Child Welfare, in a report to the Union's General Council, September 1966.

helping ADOPTING COUPLES COME TO GRIPS WITH THEIR NEW PARENTAL ROLES

EDITH M. CHAPPELEAR

JOYCE E. FRIED

When a husband and wife learn that their application to adopt a child has been approved, it is for them as though their fondest dream has come true. But when the child is actually placed with them, questions that ought to have been resolved through the home study process may arise. However, their reluctance to share anxiety with a caseworker after placement often makes it difficult to help them prepare for the special problems they may face as parents of adopted children. The Montgomery County (Md.) Department of Public Welfare has found the group discussion method an effective way of breaking through such reluctance.

The agency has had professionally trained social workers on its adoption staff for the past 4 years. During this time it has emphasized the preparation of applicant couples during the home study for the problems they may face as adoptive parents.

Over the years, the agency found that the early period of placement is the most crucial to the quality of parent-child and child-parent adjustment. Unfortunately, it also found that this was the period when social workers face the greatest difficulty in finding a meaningful relationship with adopting parents. At this point, parents were usually most unwilling to discuss or come to grips in any way with

the problems they might have with their children. The caseworkers felt effectively shut out by couples who had participated actively during the home study and preplacement period. For the adopting parents, once they had the baby, the focus seemed too narrow to include only themselves and the child. In talking with the caseworker, they tended to gloss over their problems and to make only platitudinous observations such as "It is as though he had been with us always."

Knowing that initial parent-child adjustment is rarely so idyllic, the adoption unit considered the following possible reasons for the failure to get a true picture of what was going on in these homes.

1. The worker's visits in the supervisory period seemed threatening to adoptive parents. The couples felt that since the agency still retained guardianship over the child it might use its authority to remove the child if the social worker thought the placement was not proceeding satisfactorily. Parents, therefore, felt a great need to emphasize the positive.

2. The couples unconsciously felt that discussion of the strangeness, fears, and changes involved in the new experience of adoptive parenthood would sharpen their awareness of the differences between adoptive and natural parenthood. They preferred to avoid the pain of speaking of something they would like not to exist. It is easier to deny an unpleasant fact than to face it, particularly in talking to a person vested with authority.

Realizing that both these reasons were probably operating to a certain extent, we wondered whether the parents might be able to help one another. We, therefore, instigated the program of group meetings to supplement the social workers' individual interviews with the parents. Under the plan each couple was to attend two group meetings in the office in the supervisory period: one, 6 weeks to 2 months after the placement, and the other, 1 week after that. One home visit was made by the caseworker within 2 weeks after placement.

The new program got underway in October 1965. Each meeting was attended by five or six couples and lasted about an hour and a half. Discussion was led by a caseworker, who encouraged the couples to participate and gradually turned the meeting over to them as much as possible, intervening only with occasional guidance. No two meetings were exactly alike. They varied with the group's composition and the leader's experience in stimulating discussion.

The only bases for membership in specific groups were the date the couple had received a child and the age of the child. Parents who were adopting children over 4 years of age met in separate groups. Some couples were having their first experience with parenthood; some already had one or more adopted children; some had children who had been born to them in addition to one or more adopted children. The age range among the couples was wide: from the early twenties to the forties.

The only common denominator among the couples was the similar situation they were in: they had all undergone a home study and had a child placed in their home by an agency—usually the Montgomery County Department of Public Welfare, but sometimes an out-of-State agency for whom the department was carrying the supervisory responsibility.

The discussions were always concerned with the adjustment involved in becoming an adoptive parent, the kinds of problems that could be anticipated, and how they might be met.

The meetings

The first of the two meetings each couple attended was focused on the subject "Being Adoptive Parents"; the second, on "Being an Adopted Child." The discussions covered the following aspects of adoption:

1. The difference between adoptive and biological parenthood.
2. Helping a child to an acceptance and understanding of his adoptive status.
3. The adoptive parents' feelings toward the child's biological parents.
4. The adoptive parents' feelings about illegitimacy.
5. Letting persons outside the family know that the child has been adopted.

The group leader always opened the first of the two meetings by explaining the purpose of having them—giving the couples an opportunity to discuss a common experience and problems of common concern. She pointed out that the agency's workers were always ready to be of help, but that in a way they were on the outside looking in and that the agency believed the participants as new adoptive parents might have something to say to each other. In almost

Both Edith M. Chappellear, left, and Joyce E. Fried were on the staff of the Montgomery County (Md.) Department of Public Welfare when they wrote this article. Mrs. Chappellear as adoption supervisor and Mrs. Fried as a caseworker in the adoption unit. Both have recently left the agency because of family responsibilities.



every group, the parents in their first meeting began to discuss questions their friends, relatives, and acquaintances had raised—questions they resented and did not know how to answer. Almost all had been asked what they knew of the child's background. To this, many of them had given angry, evasive answers such as "none of your business." Some had even been asked if they could really love an adopted child as they would a child of their own.

Often during the first meeting a parent would express concern about how his adopted child would look on him and whether the child would feel he had no need to respect or obey him because adoptive parents are not "real" parents. In discussing this possibility, the group members usually decided that it might happen, but then someone—sometimes the group leader, sometimes one of the parents—would point out that even children living with their "real" parents often had moments of rebellion, and examples would be cited of such children who had accused their parents of not being their "real parents."

The parents were nearly always unanimous in feeling that they would have difficulty in discussing the subject of adoption with their child. In the first meeting, the group leader did not usually make specific suggestions in regard to this problem but, rather, suggested that the parents think a lot about what they might do, read about what others had done, and plan to discuss the subject again in the second meeting.

The second meeting usually started with a reading of the minutes of the previous meeting after which the group leader would ask whether the participants had any questions they would like to discuss further. Often the first question raised was whether it is important to discuss the fact of adoption with the child. All of the parents had been encouraged to explore the subject in their individual interviews with the social worker before a child had been placed with them. The questions of "when" and "how" usually elicited much difference of opinion. In one group, for

example, a man who had adopted four children from different agencies said he felt he could tell them all that their parents were dead.

"To me," he said, "they are dead. If the children believe they are living they will go to the ends of the earth to find them."

His wife did not agree with him. Other couples said they understood his wish to "bury the parents" but tried to explain to him why this would not "work." They said that they could not in good conscience falsify the facts, that it would be easier for them to help a child face and accept the facts behind his placement than to live with a lie. Some parents said they felt that "truth will out" anyway, that as the child got older and learned more about the frequent association between illegitimacy and adoption, he would begin to wonder if his adoptive parents had been entirely truthful with him. All of the parents in the group indicated they felt they could not comfortably repeat an earlier falsification, nor did they wish to jeopardize their relationship with the child by admitting they had lied originally to protect him.

The group leader always encouraged the participants to talk about why it would be difficult for them to bring up the subject of adoption with their child. Usually it turned out that their difficulty was closely related to their feelings about the child's out-of-wedlock birth. As one participant expressed it: "It's hard enough to talk to a child about sex without having to talk about birth out of wedlock." Some parents tried to reassure themselves that out-of-wedlock birth would have no stigma by the time their children were old enough to ask questions.

The leader would then encourage the participants to discuss their feelings about illegitimacy in general, how these feelings were affecting their feeling about the natural mother of their child, and what other feelings they had about this "unknown" (as far as they were concerned) woman or girl. The reactions were as varied as the personalities of the participants. There was usually at least one parent who said the mother "didn't care" that she had "dumped the baby with the welfare." This was always countered by other with compassion—"She will always remember," "The birthday will be terrible for her," "She tried to give the baby what she couldn't give by herself—a family."

When the discussion revealed the parents' negative feelings about unmarried mothers and even some fear that their adopted children might become as "irresponsible" as the women who bore them, the group leader would ask the parents why they themselves

had come to the agency and then would try to help them see that an unmarried mother who has released her baby to an agency for adoption has shown the same sort of responsible concern for the child's future as has the couple who has come to a social agency to secure a child for adoption. When the group leader asked what kind of information about the mother of their child might be helpful to them, the parents would usually respond that they did not want to know very much.

While the major part of both meetings was spent discussing the effects of adoption on the parent-child relationship, the group leader would always make a point of bringing the discussion around to the danger of overemphasizing the fact of adoption both in the parents' direct dealings with the child and in their search for causes of whatever behavior difficulties may arise.

The leader always closed the second meeting by expressing the agency's belief in the ability of adoptive families to become closely knit, loving families.

Because only two postplacement meetings were held with each group, we did not attempt to do anything more in these meetings than to raise questions and to help adoptive parents talk about them together so that they might become more comfortable in their new parental role.

After nine series of meetings, we sent a letter and

Alert to the wonders of a new environment, this little girl, just placed for adoption, is in a home of her own for the first time.



a questionnaire to the 44 couples who had attended them in an attempt to evaluate the program. The couples were not asked to sign the questionnaire. The letter explained that the meetings had grown out of the agency's desire to help the parents discuss problems of concern to all of them. Thirty of the couples filled out and returned the questionnaires.

Parents' opinions

The following is a list of the questions with a summary of the parents' responses:

1. We did (or did not) find the postplacement group meeting helpful—21, did; 7, did not; 2, "somewhat helpful."

2. Did the meeting evoke any new questions in your minds concerning adoption? If yes, what are they?—1, yes; 25, no; 4 returns showed no response to this question. A specific question was not mentioned.

3. Did you find the subject matter stimulating?—14, yes; repetitive?—5, yes; moderately interesting?—7, yes; not pertinent?—2, yes; a waste of time?—none; no response—2.

4. Did the questions raised cause you to worry? If yes, which ones?—1, yes; 28, no; 1, no response. (The respondent who answered "yes" did not explain.)

5. Please check which, if any, of the following subjects seemed appropriate to your present experience and worth talking over in a group: (a) Adjustments involved in becoming a parent—7; (b) difference between adoptive and biological parenthood—4; (c) helping a child to an acceptance and understanding of his adoptive status—23; (d) adoptive parents' feelings toward child's biological parents—5; (e) adoptive parents' feeling about illegitimacy—3; (f) sharing knowledge of child's adoption with outsiders—12.

6. Did you feel free to express your opinions and feelings at the meetings?—26, yes; 4, no response.

Twenty couples offered suggestions of topics they would like to discuss in future meetings. Most frequently mentioned was the desire to speak with a couple who had been adoptive parents for some time.

The four caseworkers who conducted the meetings regarded them as varying in their effectiveness. In some of the sessions, the discussion was very lively; in others, the leader was hard put to stimulate any

kind of discussion. In general, we found that couples whose ages and family situations were analogous and whose adoptive children were of similar ages seemed to have more to say to each other than to couples whose family situations were markedly different from their own. We found, too, that the couples were often more interested in exchanging pictures of and pleasant anecdotes about their children than in thinking out loud about the problematic and emotional aspects of adoption. Several parents said at the meetings that the problems seemed "so far in the future" that they found it difficult to theorize about how they would meet them when and if they occurred.

Nevertheless, the answers to the questionnaire showed that 23 of the 30 responding couples found topic 5c—helping a child to an acceptance and understanding of his adoptive status—the most "appropriate to their present experience and worth talking over in a group." This, of course, is the crux of the problem.

What of the 14 couples who did not answer? Since we did not require the returns to be signed, we have no way of knowing who responded and who did not. Perhaps in some instances the questionnaire was not received because of changes of address. For the majority of those who did not respond, however, one or the other, or both, of the following assumptions may apply:

1. The couple was reluctant to indicate a negative response and, therefore, did not reply.

2. The child seems to have become so much a part of the adoptive family that the parents have not wanted to be reminded of the adoptive status.

In either case, it is difficult if not impossible to tell whether the meetings were of value to these couples.

Some of the agency's caseworkers who have not been directly involved in the group meetings have expressed some skepticism about their value. They have not relished the possibility of being exposed to criticism from a group of parents who by and large have resisted their efforts to be of service in individual interviews. The agency has, however, come to the conclusion that it is better to help adoptive parents in a group situation than in a one-to-one relationship. It is, therefore, continuing to carry on group meetings, and at the same time it is seeking ways to improve its service to adoptive parents through a combination of individual and group approaches.

THE GROUP PROCESS

in helping

PARENTS OF RETARDED CHILDREN

ARTHUR MANDELBAUM

● When parents are confronted with the fact that their child is retarded, they often enter a period of mourning and grief, accompanied by emotional isolation and loneliness. They feel like exiled aliens in a world that has turned suddenly and unexpectedly cruel and harsh. Such loneliness, tinged with vague, obscure, and little understood feelings of guilt and shame, tends to lead to silence. Communication becomes unbearably difficult and isolation increases.

The human spirit, however, with its vast capacity for enduring stress, develops inner defenses and methods of dealing with sorrow. One human attribute is restlessness, a refusal to be content with the world as it seems. Parents of retarded children have a way to express their discontent, their wish for creative action, by joining together in an association of parents of retarded children. The purpose of such an association is to sustain and strengthen individual parents who are trying to handle similar problems and, thus, to halt the unbearable feelings of being alone and isolated. By thus joining together, parents not only meet important needs they have in common, but also use their collective strength to help their retarded children. They organize and build day-care facilities and training centers, urge the public schools to include special classes for retarded children, raise

money for research, and persuade legislatures to pass laws aimed at improving State institutions.

All these efforts have salutary effects—the parents emerge from their isolation, and services for retarded children improve. But what of the parents' interior life, their inner feelings? As Bernard Cohen has noted "the stability of the interior environment is the condition of free life."¹ How can such troubled parents be helped to find inward stability and freedom?

One way found to be effective in helping such parents come to terms with themselves is to bring them together in small selected groups under the leadership of a professional person who can help them share common educational, social, and emotional experiences in a way beneficial to each member of the group.

The following analysis of the process that takes place in such groups is based on my experience as a social caseworker who has worked with several small groups of parents of retarded children in the past 7 years—some made up of mothers and fathers, some of mothers only. The groups met once a week for 1½ hours each session. Some groups ran for six sessions; some for 10 or 12 sessions; some, even longer. The members of the groups themselves determined how long they needed to continue meeting together.

The group process is used to help each member to bring forth his concern, anger, and thoughts so that gradually his strength comes to the fore and he can use it more creatively and independently in handling

Based on a paper presented at the 1967 meeting of the American Association on Mental Deficiency.

the social and emotional problems stemming from his child's retardation. If the group members can express both their positive and negative feelings and the leader is not critical, hostile, authoritative, or judgmental and is skillfully able to ease communication, then each can grow through the experience. As each member gradually gains more knowledge of himself and of the others in the group, he expresses himself with greater freedom and spontaneity. He learns his wife has feelings he did not know she had and had not recognized in himself. He also learns that she and others have feelings that he thought existed only in himself. He begins the difficult task of learning to listen to *others* talk about *their* feelings, not only to himself. He listens to ideas expressed in a continuous, evolving process and gradually becomes aware of the intense feelings behind them and of how little he knew of this before. He may then come to understand some of the sources of his own angry feelings and to sense that they are rooted in irrationality, disillusionment, and failure to realize his dreams.

Some themes

Perhaps the most significant aspect of a group process is the opportunity it gives the parent to further resolve his grief. This is necessary before the parent can release his capacity for profound understanding. As Solnit and Stark have said: "Coping with the outer reality of a child with a congenital defect and the inner reality of feeling the loss of a desired normal child requires a great deal of mental work. Such psychic work is slow and emotionally painful, and it proceeds through the gradual and repeated discharge of intense feelings and memories. These mental and emotional reactions enable the parent to recognize and adapt to the reality of the retarded child."²

In many young or comparatively young parents who have the major part of their lives still ahead, the trauma they experienced when they first learned of their child's mental defect remains a raw wound.

Mrs. A. spoke dramatically of a dream she had had several months before the birth of her child. In the dream she climbed up to a balcony and then dropped the baby over, shattering him to bits.

Several persons in the group gasped, and several other mothers said quickly that they too had had premonitions of disaster before the birth of their children.

Mrs. A. said that while she was pregnant she had seen a TV program concerning the mercy killing of a mongoloid baby. She recalled being greatly upset and thinking, "How dreadful if my

baby would be like that." She described her feelings when she learned that her baby was "like that": "I was in shock, I couldn't believe it, I couldn't think."

Mrs. E. told of an experience her sister-in-law had had with an impersonal and busy doctor. His way of letting her know of her misfortune was to remark casually as he left her hospital room, "You have a retarded child."

A shocked silence followed. Mrs. F. said softly, "I imagine it must be hard for the doctors also."

After some moments of further discussion, the worker asked whether the parents thought it was hard for a doctor to tell parents they had a retarded child.

Mrs. G. said her doctor had tried to tell her a little every day about her baby's condition. She thought he was afraid she might not be able to take it. Finally one day she said to him, "For goodness' sake, tell me the truth." He did. Her husband, who already knew, brought her books on the subject. But that proved to be the wrong thing to do. Her husband meant well, but some of the books contained wrong information.

Mrs. B. said she also read books about retarded children; some of these books were sentimental and phony, but, "I did learn a little about the subject."

Mrs. C. shrugged, "I was in shock, but I got over it right away."

Mrs. G. laughed in a challenging, anxious, skeptical way. Mrs. C. insisted, "But I did. I realized it was not too bad to have a blind child because they can do many things for a blind child. I didn't know then he was also retarded."

Mrs. D. said that for a long time her doctor did not know about her child's condition because "doctors still don't know many things."

Mrs. G. described how hard it was for her to tell her mother about her child's condition. Tears came to her eyes as she related how both she and her mother wept. This led her to talk about how the child cried almost incessantly. She said she needed to keep faith in God.

Some parents express their fear of having more children and their envy of other parents:

Mrs. A. said that when she sees other couples having healthy babies, a pain hits her; she thinks she is jealous. Mrs. B. said she is jealous, too, but that she knows it is wrong to have such feelings.

The discussion then turned to parents who have normal children and complain about them or abuse them. The feeling that "they do not know how lucky they are" was expressed vehemently and often.

Some themes, common to all discussion groups of parents of retarded children, are introduced with insistent force early in the group process: feelings of isolation, of loneliness, and of inability to communicate with others are quickly recalled.

Many parents tell about how impossible they found it to speak to anyone after the shock of learning about their child's condition. It seemed to them then that there was no one available to listen, at least no one

capable of understanding. Professional people could not understand—they seemed, in a sense, like the parents themselves, human, fragile, fearful, lacking the courage to face the problem, to speak about it, to talk honestly, directly, and kindly. As outsiders, they could not *really* understand.

Then the parents begin gradually to bring up their feelings of anger and frustration, forbidden, dreadful feelings that produce a sense of guilt they have tried to control or deny. Some parents think that perhaps the angry feelings within themselves have a magical power and may have impaired the fetus at conception or during gestation. Some wonder whether their child's retardation is not a punishment from God because of their past sins, or whether God has not blessed them by giving them a retarded child as a symbol of innocence, purity, and holiness.

Parents always express these thoughts about God, tentatively, with awe toward mysterious, seemingly irrational forces and at the same time with bitterness, irony, and doubt. The question persists: "What did I do to have had this happen to me?"

Feelings toward the children

Feelings toward the retarded children gradually emerge. Some parents see the children as grotesque objects to be hidden from public view and from friends and relatives. As such feelings come to light, they become attached to the parents' self-image. The parents feel inwardly grotesque and are afraid of being regarded as genetically imperfect, contaminated, and inextricably identified with the damaged child.

Mrs. Z. said angrily that before her retarded child was born, her mother-in-law boasted that among her 14 grandchildren there was "not one crooked finger."

Mrs. Z. said with a laugh that she thought there was a little of the mongoloid in all of her other children too, as several of them had the simian line and blunted fingers. After the birth of the retarded child, her mother-in-law would not go near him. She suggested that the Z.'s place the child in an institution and was disappointed when they took him home. Once when the father was going to visit a relative, she urged him to take one of the normal children along so that "they could see you are capable of having normal children."

As the parents describe the cruelty of others toward them in their misfortune, many reveal their own harsh and punitive views of themselves. These are gradually modified by the gentle, kind, perceptive judgments offered by other members of the group.

Mr. S., in an angry voice, told about taking her retarded daughter to a party and, after leaving her side for only a few

minutes, being accused by the child of trying to abandon her. Mrs. J. described her embarrassment when she took her retarded son to get a haircut and he tried in his jumbled speech to talk with the barber. Mrs. V. told how *her* son had run excitedly into the living room speaking incoherently when the family was entertaining company. When she tried to calm him down, he had become so excited that she had to send him to the basement. Mr. and Mrs. F. admitted rather shamefacedly that they never took their daughter anywhere because she was so obviously retarded. Mrs. S. confessed that when she took her daughter anywhere she had a strong impulse to shout, "She's a retarded child!" and had real difficulty in controlling it. The group, shocked, fell silent.

The worker pointed out that all the parents apparently had these feelings of embarrassment and discomfort and asked what understanding, what thoughts they had about them.

Mrs. F. said "shame and humiliation." She said she felt like hurling something at them, those who looked at the child, those who thought she was different; she wanted to attack them and defend her child. Mr. V. said "resentment and anger" for having such a child. Mrs. E. said, "I want to say to them, well, what are you looking at?" Mrs. T. said, excitedly, "I used to do that, think that. I used to stare at them, but now I avert my eyes." Mr. F. said, "I am guilty of that, too. Inside you feel inferior, ashamed."

Mr. T. said they had left their daughter Betty at a party that night with great apprehension, for they had never left her at a party before. "My mind is there while I am talking," he said. "Betty talks, talks, talks. The people we usually leave her with when we come here are out of town. It is important to come here; we have never talked about our feelings about her with anyone else before, never even with relatives or friends." Mr. F. said, "We come here for the child as well as ourselves."

Mr. E. said he wondered whether all these feelings we were talking about were not due to the hurt inside the parents. The child, he thought, does not suffer so much as the parents. Mr. T. agreed, "It is because you feel there is something wrong with you that you should have a retarded child."

Mrs. F. spoke of knowing a 19-year-old retarded boy whose parents take him everywhere. "Maybe it is our fault when our child embarrasses us. Maybe he picks up our feelings about him."

Eventually, the group enters a period of alternating grief and solace: themes of loss and death alternate with themes of how gentle and lovable retarded children are and the solace they offer the family. The parents' fears that the children might die are based on reality, for many retarded children have other congenital defects that add to the difficulty of caring for them and fill their parents' days and nights with apprehension.

The parents praise each other's children, and during the expression of such positive feelings they slowly venture to speak of their anger and fright at the persistent intrusion of intense death wishes. Many say in effect, "Having a retarded child is like having a death in the family, only worse; at least you can get over a death, but this is never behind you. You

have to live with this—for the rest of your life.”

When the group members become aware of the intense feelings this theme arouses, they move away from it. Many indicate they do not want to look ahead very far. Groups are often quite free from expecting false assurances and are quick to challenge platitudes. The retarded child is an inescapable reality. The future is feared because the child must surely present more difficulties as he grows; his faults and defects will be magnified. Some parents express the wish that the child will remain an infantile love object to be cuddled and pampered, of whom little need be demanded. Conversely, some parents note that in remaining like an infant the child will be an ever-increasing burden, tyrannical in his need for attention and care.

Each parent in a couple seems to fear that the other will be drawn to the retarded child so strongly that all others in the family will be neglected. This leads to anger and a sense of guilt in an alternating repetitive cycle.

Parents often screen their doubts and misgivings about the extent to which they might express their innermost thoughts in the group with expressions of concern about what to tell their other children, relatives, friends, and other persons in the community. However, parents frequently say they feel both relieved and surprised after they *have* expressed a strong negative feeling or fear. They wonder that they have been able to say things in a group that they had never been able to say to a husband or wife or a best friend. Their feeling of relief, however, is soon followed by further doubts and fears of revealing deeper feelings.

So great is the need among such parents to protect their self-esteem that a group sometimes subtly divides into sections: one, parents of children who are only mildly or moderately retarded and have only slight or no physical defects; the other, parents of children who are severely retarded or whose retardation is also apparent in their physical appearance, as with mongoloid children.

Signs of strength

Each member of the group feels defeat, but many have also had experiences that have given them a sense of victory—moments of small triumph whose import they feel the “outside world” is not equipped to understand. For example, a parent may say, “Our retarded children are different; we can shed tears together. But we are alert to and take pride in every

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sign of small improvement in them. Every slight step forward, which would be unnoticed in our normal children, is a major triumph in the handicapped child.”

The group members usually identify with one another in an intense and binding fashion. They seem to feel that since their children are unusual, they themselves are unusual also and belong together. Sometimes they are united against the “outside world”; sometimes against the leader of the group a representative of that outside world.

Mrs. T. said that for 2 years she would not admit to herself that her child was retarded. She recalled the first doctor she had consulted about the child, and she said she hated him. Mrs. N. suggested that perhaps Mrs. T. hated the doctor because he was the first person to tell her about her child's retardation. Mrs. T. agreed. The discussion then became heated as the group members spoke of doctors, how they were told about their child's handicap, and their need for someone to talk with.

For the first time, two or three parents spoke at once. The worker, raising his voice slightly to be heard, pointed out that the parents were saying three important things: first, that the doctor, by giving them the diagnosis, had hurt them; second, that the doctor had failed to help them in the way they had wanted at the time of their first deep shock; third, that they had found consolation in talking with others with the same kind of problems through the parents' association and that outsiders did not understand and could not help very much.

The parents agreed to this. Then the worker pointed out that several times previously he had tried to get into the discussion but that they had been so intent on getting their points across that he had not been able to do so. He asked whether they were aware of this and, if so, whether they could understand why

Mr. P. quickly said, “You are an outsider, too.” The worker said he thought this was an important point. Mrs. T. pointed out that one of the “professionals” on the staff of the parents' association was supposed to attend a meeting of the school board but had been “too busy” to do so. If he were a parent of a retarded child, he would have been there, she added, but professionals did not have the same kind of concern as parents. Mrs. N. said that the man's absence probably had nothing to do with his being a professional person; even some parents had to be pushed to attend meetings.

When the group session ended, the parents remained stand-

ing outside the building as the worker drove away. Mrs. S. waved goodbye, saying, "You see, we are going to continue outside in the cold."

As the discussion explores the labyrinth of feelings, the parents grope toward mature ways of viewing behavior in an attempt to find a value system that is right for them, one that will sustain and nourish them. They support one another, bring out feelings for the scrutiny of the group, question irrational ideas, point up the inefficiency and dubious value of certain kinds of behavior, and gradually increase the ability of each person in the group to look realistically at the problems presented by his retarded child and ways of dealing with them. The worker must have faith in the inherent ability of the individual parent to release his capacity to do this—a capacity previously blocked by anger, conflict, and fantasies. If he does not have such faith, he will intervene hastily in the group's discussion and become authoritative and didactic, and in doing so dilute the emotional intensity of the experience for the parents.

The leader's role

Using the group process to help parents is an increasing clinical practice in service to the mentally retarded. The worker who attempts the process must be skilled in dealing with persons in one-to-one interviews, *preferably before* he attempts to deal with them in groups. If he chooses the group method because he is discontent with the one-to-one method, he should know that in trying to help individual parents through the group process he takes on a task of greater complexity, one requiring an understanding of the dynamics not only of individual behavior, both normal and abnormal, but also of the behavior of groups. If he is discontent with the slow, cautious movement in the one-to-one process and expects a more rapid progress in working with a group, he will be disillusioned. In either method the worker must be aware of the recurrent nature of grief in parents of retarded children and of the adhesive quality of their inner conflicts. He must know that he will win the group's confidence and trust only after repeated trial and error and that each member of the group grows at his own pace.

It is tempting to use the group meeting to teach parents facts about mental retardation, to answer their questions about their children, and to discuss at length the reasons for their children's slow development. Listening and observation, however, will

quickly show the worker that many parents in the group are very well read on the subject of retardation and that some have become learned on specific aspects of the problem and are much closer to being masters of the subject than the worker. Instead of teaching, the worker helps the parents deal with their inner problems by using his knowledge that sorrows can be borne if they can be put into words or into a story; can be absorbed or dissolved if they can be expressed in words to those who face the same inescapable adversity and who wish to examine that adversity as it affects their inner selves. His task is to help the parents see the import of what they are saying and feeling as the discussion weaves back and forth between the way individual members feel about being parents of a mentally retarded child and how and what they understand about their world, themselves, and each other.

To the group the worker is an outsider. As the parents speak about professional people not understanding, about their treating parents abruptly and harshly and not helping in the way the parents want and expect, the worker must use the strictest self-discipline to control his anger, for it becomes clear that the parents also consider him an outsider incapable of helping them and unable to understand their feelings because he has not had the same shattering experience as they.

The worker is like a screen against which are projected the parents' feelings toward all outsiders as critical, uncaring, judgmental, and punitive. He represents all authoritative figures who have failed to protect the parents from an irrational and malignant fate, who will not give answers, and who force them to think for themselves.

"Will no one give us answers to our grief, will no one hear us?" The cry at first silent is soon voiced more and more. The language of the group is commonplace. It is concerned with the ordinary aspects of experience, but suddenly, and sometimes without warning, it slips into expressiveness or expressions that give the speakers themselves a shocking glimpse into their deeper feelings—

"Do you ever get over it, the depression, I mean?"

"I felt that being around friends who were pregnant was like some curse."

"What did I ever do to have had this happen to me?"

"Sometimes, I wish he had died at birth; the doctor should have killed him and not told me."

"When I did bring the baby into the store, the clerks all admired her and cooed. I wondered whether they knew she was retarded and they did that just to please me. Then, when I

didn't bring the baby, they asked about her. I felt guilty and wondered whether I had left her home because I was angry. Maybe the fact is, I'm too sensitive."

The conversation is sometimes drab, superficial; the speakers grope to convey information, search restlessly for contact, for understanding, for an illuminating explanation of the myths, theories, and conflicting beliefs about retarded children. In this search they express fear that the worker will see them as damaged, inferior, and ill and will not see their strength. Then, of course, they hesitate as though wondering how much it is safe for them to see and understand.

They become angry and seem to feel that the group process means they are to devote their lives and their dreams exclusively to the retarded child, to the neglect of their other children and themselves.

They seem to wonder: Are they in bondage? Will the worker let them go? If they express the full measure of their thoughts, their anger, will they be able to control those feelings after they leave the group and do not have each other for support?

They seem to wonder, too, about the worker and his relationship to them: Will he, because of the intensity of their concern and anger, become overburdened and ill? Is he preoccupied with his work, too professional, insensitive, and unobservant to know how they really feel? When a meeting is canceled because he has to be away, where does he go and to whom does he give the words of wisdom that he is denying them? How can they make him do their bidding and gain mastery over him so that he can gratify them more?

These and other questions the parents sometimes ask directly, sometimes imply in their questions or statements about their retarded children, their families, and their lives outside the group. But little by little they delve beneath the clichés and superficial

questioning to deeper layers of meaning until they can see the hitherto undreamed of nature of their own true feelings.

Time and time again, parents express surprise about their former narrow views of their families, other people, and the institutions of society and what needs to be done about them. They also express hope about finding ways to handle the tasks ahead of them.

The end of these sessions is like the termination of a voyage. The passengers have come together; have talked, laughed, cried, struggled to share feelings and to achieve deeper, wider understanding of themselves and their children. They have formed close friendships. Now it is time to say goodbye.

The members of the group express regret that the group cannot continue in its present form. They express fear of letting go of something that has been helpful and of being alone again. Each member, however, as a member of the larger association of parents of retarded children has an opportunity to help formulate and work in behalf of retarded children. Having, through the group process, focused his attention on himself and on others in a series of interactions in which he both gained insight and lost some of his exclusive preoccupation and self-interest, he is the more ready for social action. For as Aldous Huxley has noted, "The more inward we are, the more we may undertake outward activities the less inward, the more we should refrain from doing good."³

¹ Cohen, Bernard: In the foreword of "An introduction to the study of experimental method" (Claude Bernard). Dover Publications, New York, 1957.

² Solnit, A. J.; Stark, M. H.: Mourning and the birth of a defective child. In *The psychoanalytic study of the child*, vol. 16. (Ruth S. Eisler et al., eds.). International Universities Press, New York, 1961.

³ Huxley, A.: *The devils of Loudon*. Harper & Bros., New York, 1953.

Youth will not be well served if we assume tomorrow's world as an unchangeable "given"—a mere . . . extension of the world we presently know. . . . I find no joy in being adjusted to measureless violence, hand-to-mouth and catch-as-catch-can existence, or to a deepening phoniness which embitters the mind, blights the spirit, and saddens the dreaming heart of man.

Rev. Dr. Joseph Sitler, Professor of Theology, University of Chicago, to the 1960 White House Conference on Children and Youth.

SOME OBSERVATIONS ABOUT



MENTALLY RETARDED ADOLESCENTS

ARTHUR SEGAL

● The term "adolescent" usually produces an image of a young person struggling to leave childhood for adulthood. We think of his "search for identity,"¹ and his use of relationships with his peers to support his ego during this period of confusion.² We have come to regard adolescence as a distinct developmental period with its own norms and cultural values; a stage when the young person compares and challenges the forms and meaning of his own and others' behavior.³

Parents and other adults significant in an adolescent's life often try to help him through this tense period by providing him with opportunities to explore ideas and initiate plans for the future. But what of the mentally retarded adolescent? Does he feel the same kind of tension from the conflicting pulls toward both childhood and adulthood as the normal adolescent? Does he too begin to question the familiar and to wonder about the future?

Observations of young people in the work-training and recreation programs operated by the San Francisco Aid Retarded Children, Inc. (SFARC), have convinced me that they do. There are, however, subtle differences between the forms and degrees of their questioning and tension due not only to the degree of their retardation but also to the amount of self-confidence they have been able to develop through the support and understanding of adults. In many of them the normal tension of adolescence has been aggravated by the realization that somehow they are "different" and that this will make a difference in the opportunities they will find.

The mildly retarded adolescent (IQ between 53 and

68) speaks the language of the adolescent culture. He wants a job and wants to earn a salary. He is aware that he has been classified as a mentally retarded child and he resents this. He resents being expected to limit his career to work in a sheltered workshop and longs for the kind of job held by his father or friends. He speaks of sex and marriage and wants to date. The kind of heterosexual relationships he has is probably affected more by the standards of his friends than by his level of intelligence.

Mildly retarded young people are sufficiently aware of their deviance to be angry. However, their limited ability to understand abstract social relationships and to plan and control their participation in community activities often leads to diffuse expressions of emotion. They do not know where to direct their anger—at themselves or at the adults who do not believe in them. One girl described her confusion about where she stood as a person by saying, "Sometimes I feel like a child is holding on to me and won't let go."

The moderately retarded adolescent (IQ between 36 and 53) also shows awareness of the values and customs of his community and indicates a desire to participate in them. However, the participation he expects may be on another level. He is usually less socially adept and independent than the mildly retarded adolescent. His manner of expression is often closer to the preadolescent than the adolescent form and his display of interest in adult customs usually reflects this. He regards work as fun but play as more fun. He approaches boy-girl relationships shyly, usually with a lot of giggling and perhaps

some hand holding. He tries to imitate the adult he sees on television, the adult he believes he should be, and his inability to do so is evident to him.

The moderately retarded adolescent is also aware that the activities and accomplishments expected of him in "school"—for him a special class for "the trainable mentally retarded"—differ from those expected of his brothers and sisters in regular classes, and he speaks of wanting to learn to read and to acquire other academic skills. He is aware that children become adults when they complete secondary school. He has a general idea of the tasks and relationships expected of adults, and as a result he feels somewhat in limbo—no longer a child, yet barred from adulthood. Then what? One 18-year-old boy, upon graduation from the school's program for trainable mentally retarded children and adolescents, summed up his state as now "half a man and half a kid."

The severely retarded adolescent (IQ between 20 and 36) also has some awareness of his "difference," but he usually has some difficulty expressing himself. He has fewer words at his command and his understanding of others appears to an observer to be limited to their connection with his familiar routine. However, what seems superficial to the observer of a severely mentally retarded adolescent may reflect the observer's inability to communicate with him.

At SFARC we learned through various techniques such as the casework interview, role play, and puppetry that an older teenager who is severely retarded may still have specific interests related to his chronological age rather than to his level of intellectual development. For example, one girl let us know in very few words that she liked to play checkers with her 6-year-old cousin but that she did not play with dolls because "they are for kids."

However, the ability of a severely or moderately retarded adolescent to recognize that he is different does not mean that he necessarily understands the nature of this difference. When a group of such young people are together their discussion often reveals their identity confusion, their desire to be adults, and their limited understanding of adult ways. This is illustrated by an excerpt from a record of a meeting of the Hawks, a recreation club of moderately retarded adolescent boys.

When the group voted to visit the zoo, Jerry suggested that they also visit the adjacent playground. The boys thought this would be fun. Then Tom asked about activities at the playground. Jerry, who had visited the playground several times, answered, "swings," and smiled with a look of anticipation.

There was a momentary silence. Then Ron, Tom, and several other boys pointed out, sneeringly, that swings "are for kids" and they were adults. Jerry looked confused, and Bill said he thought adults could go on swings. However, the majority of the boys voiced strong negative feelings about acting like kids, and the decision veered in the direction of adult behavior.

But what is adult behavior? While these young people obviously saw it as "not childish behavior," they could not easily say what it was nor follow through in a determined way.

The confusion among severely and moderately retarded adolescents about what an adult's role consists of may be due not only to their low level of intelligence but also to their lack of opportunity to learn the things that other adolescents learn incidentally in their daily lives. For example, in one of the discussion groups of moderately retarded adolescents conducted at SFARC to promote a greater degree of self-confidence in the retarded, some of the young people talked about how much they would like to live alone, but they showed almost complete ignorance about what a person who lives alone has to know and do. They knew almost nothing about the prices of food and rent or the tasks involved in getting in supplies, preparing meals, and cleaning house. But after they were taken by the social worker on trips to grocery and department stores and listened to a landlord talk about rents and the kind of care a tenant has to take of the rented unit, they begin to show a more realistic understanding of what it means to be an independent adult.

Effects of labeling

Identity confusion may stem from a multitude of inconsistent and distorting experiences in the mentally retarded person's life. From the time he has been labeled as mentally retarded he has been regarded as a social deviant. As a result he has been put into a mold which inevitably has shaped his personality. For example:

Mr. and Mrs. L. have "a cheerful little girl," Penny, whom they dearly love. Penny has Down's syndrome, and from the time the diagnosis was made the parents have been subtly influenced to use the mold. Their daughter will remain a child, she will never grow up, they have been told by physician, teacher, neighbor, and relative.

The L.'s have a good marriage, and have other children of normal intelligence. They have decided that, since Penny cannot grow up and cannot understand adult concepts, they will always respond to her as though she were a small child. They have always laughed at her antics and given her the secure care a child needs, and they have continued to do this after she is well into adolescence.

Thus, Penny has learned to expect easy forbearance and

close supervision from her parents. Since she has never had any friends of her own age, she has had neither socialization experiences nor parental encouragement to guide her into adulthood. Therefore, she does not learn new socialization methods appropriate for an adolescent.

Penny *could* learn social behavior more appropriate to her age, for many young people with her condition have done so. But as long as her parents and other people in the community and she herself believe she is a child, she will remain a child.

The same molding process takes place in some families with a mildly retarded child, though much less frequently. Our experience at SFARC with adolescents who are only mildly retarded or who are on the borderline between retardation and low normal intelligence suggests a different set of dynamics.

Many parents who have an adolescent child who can almost make it academically do not wish to dwell on or even admit to the fact of mental retardation. They tend to push the child toward greater academic achievement or job finding. They do not wish to be counseled on ways of dealing with a retarded adolescent. Some parents only allow themselves to refer to their child as retarded because the agency accepts only the mentally retarded in its job training programs. Some only agree to accept counseling for themselves if this will guarantee their child a job. Some insist that their child is just lazy.

A mildly retarded adolescent, therefore, is apt to be caught in a vise of conflicting images and expectations. The school labels him as mentally retarded and puts him in a special class. His parents say he is lazy. He himself may be sure he is neither lazy nor mentally retarded. But he has to live with both labels, a task made more difficult by his limited intellectual ability and its effects on his social judgment. When he shows the typical tension and questioning attitude of adolescence, he receives little pertinent guidance from adults because they either see everything he does in terms of his retardation or fail to recognize the difficulties his retardation causes him.

Many mildly retarded adolescents, while vaguely aware that they have trouble learning, do not look on themselves as abnormal. Therefore, when they enter a training program in an agency whose name itself shows that it serves only the retarded, they have added to the usual difficulties of adolescence the psychological problems that come with labeling. Many of them rebel and leave the agency.

At SFARC we have seen many mildly retarded adolescent boys and girls who, having dropped out of school or completed a program of special classes,

have agreed to attend the sheltered workshop for training but have not agreed to be mentally retarded. They stay on in the workshop as long as they think it will lead to an outside job.

A survey of mentally retarded persons known to 31 agencies in San Francisco shows a discrepancy of several thousands between the number of persons of school age identified as mentally retarded and the number over 18 years of age. The following case story may offer a clue to this discrepancy:

Dan B., a mildly retarded 18-year-old school dropout, registered at the SFARC workshop. His parents placed a high value on work and independence. Mr. B. insisted Dan was lazy. Mrs. B. hoped Dan could get a job. She was not certain he was retarded.

At the workshop, Dan was sullen and apathetic. He did not like the program nor the trainees, most of whom were more retarded than he. He became embroiled in many fights. The staff tried to give him special work activities, but he would not stay.

The agency lost track of Dan for about 2 years. Then one day he appeared at the workshop beaming. He had a job with a service station and was earning a union wage. He was married, and his wife was pregnant. He returned again the day after his wife gave birth, a happy father, obviously no longer identified as mentally retarded.

When will I get a job?

Every adolescent we meet in the SFARC training program asks the same question: When will I get a job? Behind this question are many influences: cultural standards, tradition, the inner need for identification, and the need to be a productive person. Some trainees expect jobs in specific occupations in the community; others are content to remain in the sheltered workshop. Some expect a higher wage than the workshop offers; others want a wage only as a symbol of adulthood and are not concerned with its size.

The *severely retarded adolescent* usually wants to remain in the workshop where he has a meaningful task he can accomplish.

The *moderately retarded adolescent* is more likely to speak of a "real job," though he has little notion of the requirements for such a job. He may want to become an electrician, a policeman, a teacher, or, after some interviews with the agency's caseworker, a social worker. He wants to be regarded as adult, a state he equates with having the same kind of job as a particular adult he knows and admires. Most moderately retarded trainees, as they form positive relationships with the agency's staff members and gain new skill and a degree of independence, are able to relinquish their original vocational goals and take

jobs in the workshop or the community that are within their competence.

The *mildly retarded adolescent* usually has less uncertainty about his ability to become an adult and more realistic vocational aims. He wants a job in the community that pays good wages instead of workshop employment, though he may be completely lacking in any vocational skill and in the social skill it takes to get along with fellow workers and a boss. Mildly retarded adolescents are well aware of the puritan principle that commands the "worthy" to work, and so they feel greater pressure often exerted by their parents to seek work in the community.

Love and marriage

Like most young people, mentally retarded adolescents are interested in the opposite sex. In the SFARC workshop we often heard conversations among the young people about "boyfriends" and "girlfriends," about dating, marriage, and sex. However, love and marriage, though talked about by almost all the young people, have different meanings for different persons.

Among the *moderately retarded* talk about love or marriage is usually only an expression of a cultural expectation. For example, for John, who is moderately retarded, getting married is something adults do. Since he is approaching adulthood, he too will have to marry, or so he fears. When he speaks of marriage he is really expressing his search for an adult image.

Mary, also moderately retarded, is a very lonely girl who has lived in a number of foster homes. She met a boy at the sheltered workshop and soon began to speak of love and marriage. Her desire, we observed, was for a comforting relationship with a male figure. Mary and her boyfriend will both remain satisfied if they can continue their friendship.

Young people who are *mildly retarded* or near the borderline of dull normal intelligence have a more sophisticated view of marriage. They speak of finding a job, an apartment, and of all the things young people normally consider before marriage. And many of them do get married.

Many persons—especially parents of the mentally retarded and professional persons who work with them—raise strong objections to the idea of mentally retarded persons getting married. The objections raised most frequently are: (1) mentally retarded persons cannot make realistic plans; (2) they may

produce mentally retarded children; and (3) they may be unable to care for children properly. The tendency is to approach the subject negatively without recognizing the varying degrees of retardation and personality development among persons who score low on IQ tests or the lack of evidence that successful marriage bears any relationship to specific levels of intelligence. Moreover, nobody has ever developed a standard model of a successful marriage against which the marital adjustment of a retarded person could be measured.

There are two reports in the social work literature of studies involving inquiries into the marital adjustment of persons who were mildly retarded. Both show an association between marital adjustment and the personalities of the marriage partners—a result that one would certainly expect to find in a study of marital relationships among nonretarded persons.^{4, 5}

Concern about the progeny of a marital union between mildly retarded adults may be overemphasized. The etiology of mental retardation is complex. Only a small proportion of cases can be linked to known genetic factors. But the presence or absence of certain environmental factors in childhood and adolescence decisively influences opportunities for intellectual achievement and social growth whether or not retarding genetic factors are present.⁶

The ability of parents to provide and care for their children properly is determined by several factors other than intellectual ability. These include emotional stability, economic security, and community acceptance. Since marriage does occur between mentally retarded persons and some of these unions do produce children, whether or not skillful guidance is available to them is an appropriate concern.

The parents

Parents of mentally retarded adolescents often need guidance to help them help their retarded child achieve a greater level of maturity. They may be unable to let the child grow up, not because they do not want him to, but because they are afraid that he cannot and will be hurt if he assumes more independence in getting around the community, going shopping alone, or taking a job. Parents have many deep and lasting feelings of grief and sorrow about their retarded child that must be understood and respected by anyone who wishes to help the mentally retarded adolescent.⁷ Such feelings cannot be dispelled, but parents can be helped to explore their mentally re-

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tarded child's abilities and to permit him to grow up.

Parents who have had no guidance during the child's formative years are usually not prepared for understanding and helping their child when he becomes an adolescent. We have known parents who childishly teased and chided their retarded adolescent child on the assumption that he did not understand them enough to care. At SFARC we were able to show such parents that the young person does understand them and no longer wants to be treated as a child. I use the word "show" literally. Some parents have had to be shown their teenage child actually working at a productive task or participating in a group discussion before they could believe in his potential for functioning more maturely.

In contrast, some parents of mildly retarded adolescents express disbelief in their child's retardation. This is often true if the child's retardation was not recognized by anyone until he reached school or even later when the school belatedly placed him in a special class. Such placements are frequently made with little or no interpretation or guidance being offered the parents. If they have a poor understanding of English or little concern for academic achievement, they may not worry about their child until he grows older and exhibits an inability to compete socially and in job getting. Parental misunderstanding of the young person's behavior may then lead to friction and tension.

At SFARC we encouraged parents to come together in discussion groups as one means of helping them get a clearer picture of their retarded children's potentials as young people growing into adulthood. In discussing together the meaning of independence to specific retarded adolescents (their own child and each other's), the ability of these young people to assume responsibility for decisions, the pros and cons of allowing them to date members of the opposite sex and, eventually, to get married, and their chances of employment, the parents often come to see that the

potentialities of each retarded adolescent are different and to drop the tendency to say that "the retarded can" or "the retarded cannot" do something.

For example, a mother of a girl employed in the sheltered workshop repeatedly expressed the fear that something would happen to her daughter because she was taking long walks with another girl after work instead of coming directly home every day. This mother gradually relaxed when other members of the group kept telling her that her daughter was behaving like other teenage girls and was in no greater danger than they in taking a walk with a friend.

We found that parents who refuse to permit their retarded adolescent son or daughter to develop greater independence tend to be those who are uncomfortable in their relationships not only with their retarded child but also with their normal children. When we have been able to help these parents, through the group and through individual casework interviews, to relax their attitudes toward their retarded child, we have found that their attitudes toward their other children have also changed. When they finally could permit their retarded adolescent child to assume some independence, they could also encourage greater independence in their other children.

IF RETARDED ADOLESCENTS are to be helped to achieve more satisfactory lives, all those who are working in their behalf—parents and professional persons alike—must recognize that these young people are *adolescents*, with all the desires, expectations, and confused emotions that come with adolescence, and at the same time are *individuals*, each with his own personality, own special way of looking at things, and own degrees of strength, weakness, and potentiality.

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EXTENDING

A HAND

to PARENTS of DISTURBED CHILDREN

JOYCE EDWARD

Now that the right of the emotionally disturbed child to education is firmly established, those of us who work in special education can direct our efforts toward the challenge of insuring that every emotionally disturbed child likely to profit from special education receives it. To meet this challenge is not so easy as it may appear. Parents can be the greatest obstacle. Some parents resist accepting a reliable diagnosis of their children's disorder as disturbed and are unable to follow recommendations for special class placement.

Ten years of experience as a psychiatric social worker in the elementary school division of the Luther E. Woodward School for Emotionally Disturbed Children, Inc. (LEW), in Freeport, N.Y., which takes children aged 4 through 16 years, has made me much aware of the problems of the parents of disturbed children and of the measures an agency can take to help these parents accept their children's special needs. At LEW, casework with families is an integral part of the program from intake to discharge. We have found that, though placement of the child in a special class is usually painful for parents, it is a process through which they can be helped to reach a better understanding not only of their child and his needs but also of themselves. What the professional worker does can have a great deal to do with whether the parents' adjustment to the child's placement improves as the child improves or whether it disintegrates, leaving the parents even less effective than before in helping their child.

Basic to the professional worker's efforts is the

recognition of both the conscious and unconscious effects the disturbed child has on his family. The problems parents expose to professional workers reflect their individual personalities, the interactions of the entire family, and the actual difficulties they face in rearing a disturbed child.

The severity of the symptoms of such a child can of themselves make even healthy, stable families anxious and defensive. The child's hyperactivity, impulsiveness, bizarreness, regression, and obsessiveness, to mention only a few characteristics that may occur singly or in combination, place an inordinately heavy strain on family life. The behavior that makes a child unmanageable in a regular school class makes him no less so at home. His care is taxing; his behavior is incomprehensible; his conduct can be embarrassing; the medical attention he requires is costly; the social services he requires are difficult to secure; and the time his care requires is excessive. His illness is a severe blow to the parents' self-esteem, and their feeling of guilt for having produced such a child is accentuated by the hostility and anger the child provokes. It is difficult for them to air their feelings or to separate themselves from him. Even the most mature parents worry about how to handle an emotionally disturbed child without harming him further. They worry not only about the present but also about the future.

In addition to having problems directly related to the child's disorder, parents may be beset by other kinds as well. Some have serious psychiatric disorders themselves. Complicated pathological relationships may exist in the family, of which the child's

illness may have become an integral part. Some parents cannot view their child's disorder realistically because they identify themselves with his behavior. Others are so limited intellectually that they cannot understand what professional people tell them about their children. Social and cultural deprivation hinder others from understanding. Or daily problems stemming from economic want, bad health, or poor marital relations may contribute to the parents' inability to act wisely for their child.

Of course, the school is not responsible for helping parents solve all their problems, but unless the school recognizes that many influences affect the ability of the parents to come to grips with their child's disorder, attempts to secure their cooperation will not succeed. There is an important difference, for example, between a parent who fails to keep an appointment because he has no transportation or can get no one to care for other children and a parent who fails because he fears the school or is hostile toward his child. There is also an important difference between a father who in momentary anxiety and defensiveness denies that the acting-out behavior of his son represents a serious problem and a father who denies the existence of the problem because he himself is psychotic and sees his son's actions as justifiable retaliation for an imagined insult to the family. What we as professional people do to enlist the parents' support is determined by the degree to which we recognize that their actions are as symptomatic of their needs as are the child's of his.

Sometimes parents are unable to comprehend the explanation we offer them about their child's illness or, if they do, they cannot act positively on the information for various reasons. The emotionally depressed father who is told that his son needs more attention may never have been able to form a meaningful relationship with another person and certainly does not know how to form one with his disturbed child. The disorganized, perhaps mentally retarded, mother who is told that her child could benefit from sound eating and sleeping habits may be completely unable to put this suggestion into practice without a great deal of support.

It is not enough for the helping person to be aware of the parents' feelings, however. As professional persons, we must be cognizant of the kinds of feelings parents arouse in us. Our reactions to parents contribute as much to the climate of interchange as the parents' reactions to us. We all have feelings about parents as such, for we have all been children. We may transfer either positive or negative feelings,

depending on our own experience. To work successfully with parents, we have to control our own unsound reactions. We may, for example, react to the parents of disturbed children with hostility because we think they are responsible for their children's troubles. We may have a feeling that if we could only rid the child of his noxious parents and have him to ourselves we could effect a "cure."

Unfortunately, such feelings are often communicated to parents, and their recognition of these feelings may account for some of their resistance and hostility. When we realize that mental illness in childhood is the result of a complex interplay of biological and environmental forces, we will no longer assume that all parents of disturbed children are alike. Whatever contribution the parents make to the child's problem are most likely unconscious reflections of their own psychic difficulties. Our anger at the parent only increases his anxiety and impedes even more his ability to improve the quality of the care he gives his child. To control our own reactions to these parents is no easy task, for their behavior is often provocative and productive of irritation.

Parental anxiety

It has been my experience that where the parents' anxiety is primarily a reaction to the child's disorder and not symptomatic of pathology, an understanding attitude on the part of the professional person promotes the development of a positive relation between family and school. In time, this relation becomes the cornerstone for the work between the family and the school and enables the parents to trust the school's judgment and to accept the educational plan the school recommends as a logical outcome of a joint endeavor. This is never an easy process, however. When the child enters school, parents must face the child's problems squarely. The school must be prepared to work with families in a crisis and to give even healthy parents the support they need to resolve their problems and enough time in which to do it. Accepting the fact that one's child does not fit into the public school, one of the most basic institutions in society, cannot be worked through in one session. We must be prepared to help parents through a painful time when their thinking may be muddled by pain. We must remind ourselves that some conditions in life are never really accepted but are only tolerated by those who must face them, and that for most families of chronically handicapped children sorrow persists throughout life.

For mature families the process of working with persons from the school to secure the right educational plan is in itself helpful, for it tends to lessen anxiety. The knowledge we share with the family about the nature of the child's disorder, the educational plan recommended, and the child's development help them learn to control their anxiety through intellectualization. It also gives them enough time and experience to correct distortions about the child through consistent opportunities to test reality. Regular, planned meetings with parents are basic to a good special education program, and they can be as important to mature parents as to immature.

Parents who, despite the sensitive professional effort extended to them by the school, continue to deny the problem and project their difficulties onto the school cause great concern in professional workers. If the diagnosis of the child's condition is accurate, the parents' reactions to it often indicate the degree of disturbance in the family. The parents may themselves require special help. However, whatever blocks their ability to accept assistance for their child is also likely to block their willingness to seek help for themselves. Nevertheless, schools must work with these parents to the best of their ability if the right educational plan is to be made for the child.

Two cases of work with parents of children sent to LEW back up my points. In these cases, each couple's problems were reflected in the difficulty they had in accurately sizing up and solving their sons' problems. Both members of the first couple, Mr. and Mrs. G., have emotional problems of long standing that have resulted in marital discord. They are intelligent and are sophisticated about psychological problems. The other couple, Mr. and Mrs. L., are both paranoid and extremely withdrawn, hostile, and suspicious. They are not intelligent and are economically and culturally deprived. Despite difficulties, however, their family is intact and self-supporting. Both families are concerned about their children and their education.

Fred's parents

Mr. and Mrs. G. at first greatly resisted the idea of placing their 10-year-old schizophrenic son Fred in a special program for mentally disturbed children and had difficulty tolerating the placement for a long time. Psychiatric and school reports indicated that the school had tried to help Fred and had kept him in regular class as long as possible. When the parents came to LEW, they were agitated and quarrelsome,

accused each other of being at fault, and showed the resentment they felt against the school for recommending special placement. Mrs. G. soon took over the interview. Although Mr. G. seemed more realistic than his wife, he only contributed to the interview when questioned directly. But as Mrs. G. always contradicted whatever he said, he gradually grew silent.

Mrs. G., while admitting there was something wrong with Fred, said he was not so ill as the children in our classes. As the interview progressed, it became apparent that Mrs. G. hoped the caseworker would, on the basis of the referral material, confirm her belief that the school had failed the boy and that all he needed was a regular class of higher quality.

The caseworker acknowledged that it was difficult to accept a special class like ours but said she felt that, despite their doubts, Mr. and Mrs. G. knew that Fred needed something more than a regular class or they would not have kept the appointment. Because the caseworker felt that they were afraid of our program, she tried to help them learn something about the program while she tried to learn something about them.

The caseworker said she knew from the referral material that they had already spent time and money on psychiatric help for Fred and counseling for themselves. She told them she inferred from this that they felt great concern for Fred and that he had a serious problem. "Was his difficulty only something that manifested itself in relation to a poor school situation?" she asked.

After this question, Mrs. G. relaxed a little and both parents described in detail Fred's sickness and the great problems he imposed on family life.

The caseworker pointed out that their observations confirmed the reports. She then said that she wondered if it were possible for a child like Fred to learn in a group of 28 children in a regular school. Both parents agreed that he had not, although the teacher had tried to help him. The caseworker said that Fred's school seemed to have tried its utmost and that it was unlikely that Fred's needs could be met in an ordinary school.

The caseworker then pointed out that, from the description they had given, Fred's case sounded like those of some of the children at LEW, and she described some of them. "How did you feel he might differ from the pupils described?" she asked. Mrs. G. said she was afraid that neither the other children nor our academic program would stimulate Fred. "What," the caseworker asked, "has happened in the past 4 years while he was with children who per-

formed adequately?" He had either withdrawn completely or acted out in an extremely disruptive way, the parents admitted. Mrs. G. felt Fred was bright and that with proper handling he could be brought up to grade level in a short time. The caseworker described LEW's academic program and said with emphasis that, while the school offered stimulation, it was impossible to predict how a child would progress and that disappointment was often inevitable. This statement seemed to free Mr. and Mrs. G. to discuss their disappointment. Mrs. G. cried; Mr. G. looked into space.

By the end of the interview, their fear was somewhat allayed but they still had doubts. The caseworker told them that she felt they should come in again to observe the classes and to discuss the matter once more before bringing Fred in for an interview with the psychiatrist. She pointed out, however, that on the basis of their description and the referral material she was sure Fred needed special schooling. Whether our program was suitable remained to be seen. She also told them that she realized they were full of doubts and were disappointed, but she stressed how important it was to go slowly because much of the success of any program would be their feeling that it was right to try it. They did return for another interview, and after we worked slowly with them, they decided to place Fred with us.

When Mrs. G. brought Fred to school for the first day, she was upset. She wept during the interview and said that the other children "looked sick but not her son." The caseworker told her she understood the anxiety she was going through and that other parents were also anxious. The caseworker held to the belief, however, that Fred did belong in the program. The caseworker made plain to her that the school believed that Fred could be helped. She said that in time, after Fred had begun to adjust to the school and Mrs. G. could see improvement, she would find it easier to accept the placement. The caseworker reminded her that she had had similar feelings when Fred had had other services and that she had come through the experience all right. The caseworker made another appointment for her for a week later and told her to telephone if she had questions before then. At the next appointment, Mrs. G. said she had gotten through the week and that while she still did not like our program, her concern had lessened and the children looked better. The caseworker continued to see her once every 3 weeks for several months, and she gradually became more accepting. Mrs. G. still does not like Fred's being at LEW, but she has been

able to support the placement for 3 years in a constructive, meaningful way. From time to time the caseworker must reinterpret Fred's needs to her, give her an opportunity to air her disappointment that he is still ill, and answer her questions.

The personal and marital problems in this family have not changed because of our efforts, but our efforts were influenced by the knowledge of these problems. If we had not understood what was behind the parents' behavior, we could have easily become annoyed with them, particularly with the mother, because Mrs. G. displayed her anxiety through excessive talkativeness, hostility, and projection. Our basic attempt to help was focused on using the family's positive characteristics—their concern for the child and their intellectual awareness. We gave them an opportunity to express their disappointment and pain and to raise their doubts and fears about what a special class might do to their son. We always focused our efforts on reality: their son could not be provided for in a regular class despite all reasonable attempts to help him adjust. We did not attempt to get them to like the placement, only to face it with tolerance. And we gave them the continuing support they required. Ultimately, the boy's gains enabled them to accept the placement with less pain.

Darren's parents

Mr. and Mrs. L. were referred to a special program for their 10-year-old son Darren because of his destructive behavior and failure to learn throughout 4 years in school. One year before referral, he had drawn a knife on another student and as a consequence had been excluded from school. The parents regarded this exclusion as a plot by the school to get rid of Darren, who to them was a quiet, respectful son. To a quiet, withdrawn family, his silence seemed a virtue. The parents considered Darren's flareup in school as a justifiable response to provocation. They resisted special placement, disagreed angrily with psychiatric reports, and threatened to secure legal counsel. When referred to a special program for emotionally disturbed persons, they refused to apply. Darren was out of school a year. Diligent efforts by the school psychologist and the social worker for the special program, coupled with the family's concern for Darren, finally brought the parents to LEW for an interview.

All of the problems already described were evident in the interview. Both parents appeared withdrawn, hostile, and suspicious. The caseworker made clear

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to them that she shared their concern about Darren's being out of school. "What has happened since we spoke to you on the telephone last year?" the caseworker asked. Mrs. L. answered by recounting all of Darren's virtues and placing special emphasis on how helpful he was with the family ironing. The only problem he faced, she said, was not being able to go to school. The caseworker agreed that this was a serious problem. She said their keeping this appointment was a positive step on Darren's behalf, whether or not they found LEW's program suitable. Mr. and Mrs. L. quickly launched into an angry discourse on Darren's former school. The caseworker, after listening for a few minutes, said that she understood their anger but, as they had gone over this many times before without Darren's getting into school, it would perhaps be more helpful to consider the kind of schooling Darren required now.

"You have spent a lot of time with him in the last year; what do you think of his ability to learn? How did he do at school until excluded?" the caseworker asked.

Mrs. L. said that she was surprised that he had not learned to read. Even when she taught him, he did not grasp things, she admitted. When the caseworker asked her if she felt he might need special handling, Mrs. L. said, "Yes." The caseworker then asked if she ever felt that a large class might confuse him. "I guess it could," Mrs. L. admitted. At this point her hostility seemed to lessen, and she began to ask questions about the special school. The caseworker answered her questions by citing facts about LEW and indicated that the program was for children with problems, some similar to Darren's.

Later, when they visited classes, Mr. and Mrs. L. said that some children looked different or "spoke funny." The caseworker agreed that the children were troubled, but she pointed out that she thought Darren had some problems, too. They replied that they did not think he was like the other children,

but Mrs. L. felt he should go to school and perhaps it would be best to place him in LEW.

The caseworker, moving slowly, in some ways mirrored their resistance. She said she could not say immediately whether this was a good plan for Darren; the school psychiatrist and psychologist would have to see him and give a lot of thought to the matter. Perhaps home teaching was best. At this the parents immediately suggested that the intake study be conducted.

Darren was accepted, and his parents were willing for him to go to LEW by the time he was placed. In the first interview after placement, Mrs. L. came alone; she said that her husband would not be able to come. As she saw it, the family's problems with the school were really her responsibility. We did not insist upon the father's coming, although we usually try to work with both parents.

Mrs. L. immediately complained that Darren's sweater had been torn in class, and she asked whether the teacher was supervising the class properly. The caseworker told Mrs. L. she knew how hard it must be for her to have Darren's clothing torn, with prices as high as they are and a large family to clothe. Mrs. L. then related in detail the concern her many bills gave her. The caseworker let Mrs. L. know that she felt her concern was realistic and her management on a small income, competent. After this, Mrs. L. seemed less hostile. Darren had made a good start, and the caseworker gave her examples of what he was doing. She admitted that he appeared pleased about school, which was unusual for him. Mrs. L. said she guessed that with boys one had to expect a tear or two. The caseworker agreed, but told her she would bring the matter of the tear to the attention of the teacher. The caseworker then asked her if she would like to meet the teacher and see Darren's class. She said, "Yes." The visit delighted her, especially Darren's pleasure in introducing her to his class.

Mrs. L. now has appointments monthly with us, which she always keeps. During these interviews the caseworker shares with her information about Darren's progress in school, which has been slow but consistent. Darren no longer acts out as he used to, a change that has confirmed his need for the program to the parents. Mrs. L. has been gratified by the academic gains, too. The causes of some of Darren's problems come to light now and then in what she says. We asked her once about Darren's laughing at times when nothing seems to be happening. Mrs. L. said she had noticed this and thought she laughed the same way. Often she has funny thoughts that

cause her to laugh and she thought everyone else did too. We did not pursue this matter, nor did we deal with other obvious indications of family pathology. Mrs. L. developed a friendly feeling for the school. She told us how much it meant to her that there were no complaints about Darren. Although she continued to feel he was not like the other children, she thought that he was learning and that since we were not making him angry he should remain another year.

We never attempted to help Mrs. L. to understand Darren's real problem. All previous efforts in this direction had only stimulated her anxiety and tendency to act out. We worked with her as she was and tried to make the most of her concern for Darren's education. As he improved her anxiety lessened.

A focus on responsibility

There still are and will continue to be many problems in these families. No basic alteration in the personalities of the parents have been made, nor have we touched the core of their relation with their children. We have, instead, tried to enable them to allow

their children to take advantage of an opportunity for special education without interference. We have focused our efforts on stimulating feelings of responsibility rather than stirring feelings of guilt. We believe that through this process some of the parents' anxiety was diminished and that a more pleasant atmosphere was created at home, thus lessening the strain that builds up when tension between home and school is strong.

When we assume responsibility for the education of the emotionally disturbed child, we assume an imposing task. It is not placing a child in a "special" class that makes his education "special," however; rather it is the recognition of his many complex needs and an interweaving of the insight and skill of various professions to meet these needs. To do this, we must have concern for many aspects of the child's life, including the role his family plays in relation to his schooling. The most capable teacher, the finest curriculum, the most expert clinical service will be of little avail if the child's family refuses to accept a program for him or, in placing him, sabotages the school's efforts.

guides and reports

FAMILY LIFE EDUCATION—A CAUSE FOR ACTION. American Social Health Association, 1740 Broadway, New York, N.Y. 10019. November 1966. 64 pp. \$2.

Reports on a demonstration project conducted over 9 years by the American Social Health Association in 23 States and the District of Columbia through which family life education programs were incorporated in the curriculums of public schools and teacher training institutions.

BIRTH CONTROL POLICIES AND PRACTICES IN FIFTY-EIGHT CALIFORNIA COUNTY WELFARE DEPARTMENTS. Carl Reiterman. Planned Parenthood of Alameda County, 482 West MacArthur Boulevard, Oakland, Calif. 94609. 1966. 102 pp. \$4.

Reports on a survey of the policies

of California's county welfare departments concerning the provision of contraceptive services or advice.

CHILD LIFE PROGRAMS IN 91 PEDIATRIC HOSPITALS IN THE UNITED STATES AND CANADA. Robert H. Dombro. Child Life Program, Children's Medical and Surgical Center, Johns Hopkins Hospital, Baltimore, Md. 21205. 1966. 18 pp. 50 cents. (Mimeographed.)

Reports the findings of a survey of the characteristics of recreational and educational programs for children in 91 children's hospitals.

LISTEN EVERYBODY! YOUTH PARTICIPATION IN COMMUNITY ACTION: report of a demonstration training project. California Department of the Youth Authority, 401 State Building No. 1, Sacramento,

Calif. 95814. 1967. 66 pp. Copies free on request from the Department.

Reports on a 1-year demonstration project in which 182 young people from impoverished areas in California were trained to work in community improvement programs. Sponsored by the Governor's Advisory Committee on Children and Youth and financed by the Office of Economic Opportunity, the project was administered by the California Department of the Youth Authority.

UNDERSTANDING THE DISADVANTAGED: a source book. School of Home Economics and Extension Division, University of Missouri. Available from the Technical Education Services, University of Missouri, 417 South 15th Street, Columbia, Mo. 65201. 1966. 187 pp. \$1.

The proceedings of a short, inter-agency, interdisciplinary course in studying the disadvantaged held at the university of Missouri, July 13-15, 1965.

BOOK NOTES

TOUGH TIMES AND TENDER MOMENTS IN CHILD CARE WORK. Eva Burneister. Columbia University Press, New York. 1967. 274 pp. \$6.

Through child-care workers' own descriptions of incidents that have occurred in their work with institutionalized children as well as through the author's comments, this book not only presents some of the problems and principles of caring for groups of children living away from home but also gives a picture of the emotional needs and confusion common among such children. The incidents, originally described by the child-care workers as assignments in inservice training classes, are presented by the author as illustrations of points she makes in regard to specific aspects of a child-care worker's responsibility, such as the relationship with the child; finding the feelings behind a child's verbal communication; recognizing and dealing with the mood of the group; understanding a rejected child's mixed feelings about his parents; encouraging creativity in the children; and handling difficult behavior.

In the final chapter, the author points to the importance of providing training opportunities for houseparents, who in many instances themselves feel an urgent need for more competence in helping the unhappy children have happier lives. She points out that, increasingly, the children placed in institutions arrive with serious emotional problems derived from their previous experience in family and community.

JUVENILE GANGS IN CONTEXT: theory, research, and action. Edited by Malcolm W. Klein in collaboration with Barbara G. Myerhoff. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1967. 210 pp. \$3.50.

The 15 papers in this symposium discuss the nature and causes of gang juvenile delinquency and the effectiveness of methods of working with street gangs through "detached" workers to bring

about constructive change. They are presented under four heads: patterns of gang behavior, relation between perceptions and behavior, sociological contexts, and action programs. The authors include administrators, practitioners, and research workers in programs of delinquency prevention. The last section describes programs in New York City, Chicago, and Washington, D.C.

ADOLESCENCE: care and counseling. Edited by Gene L. Usdin, M.D. J. B. Lippincott Co., Philadelphia, Pa. 1967. 238 pp. \$7.

Stressing the need for understanding (and the "desire" to understand) the adolescent in his struggle to find his identity in today's world, this group of papers by psychiatrists and other physicians is directed to professional persons, especially physicians, to whom adolescents are most likely to turn for help with problems. The papers discuss the normal, physical, and psychological changes of adolescence and adolescents' relationships with adults, as well as the effects of social change on adolescents and on the nature of the adolescent subculture.

Some of the specific problems discussed are religious-psychological conflicts, sexual morality, disguised depressions, learning problems, antisocial tendencies, the effects of drugs used in treating emotional disturbance, and parents of adolescents with problems.

In his introduction, the editor finds "healthy signs" in the increased openness of adolescents about their behavior and values, which he sees as representing "an honest groping toward a new and more complete maturity." Calling for more responsible leadership from adults in helping adolescents to reach this goal, he points to the often overlooked opportunity presented to physicians to provide them with effective counseling. Adults, he points out, should not lose sight of the "ageless truth" that adolescents "are the product

of the times and not the source of our difficulties."

These papers were presented at a symposium on adolescence held in December 1966 by the Tonro Community Mental Health Center of New Orleans with a grant from the National Institute of Mental Health.

PARENTS, CHILDREN, AND ADOPTION: a handbook for adoption workers. Jane Rowe. Humanities Press, New York. 1966. 294 pp. \$6.

The unmarried mother and her child are the central figures in this book, which brings together information from the fields of medicine, genetics, psychology, law, and social work in discussing the theory and practice of social casework in services to unmarried mothers and in child placement for adoption. In discussing work with the natural parents of a child born out of wedlock, the author stresses the importance of working with the father as well as with the mother. The aspects of adoption she discusses are: heredity and environment as they affect the child; homefinding, planning for placement, and placement; the legal procedures; and supervision of the adoptive home.

The author has worked in the child welfare field both in her native England and in the United States.

CASEWORK WITH FAMILIES AND CHILDREN. Edited by Eileen Young-busband. University of Chicago Press, Chicago, Ill. 1966. 175 pp. \$1.75 (paperback).

A collection of 14 articles reprinted from British and U.S. social work journals and other publications, this book discusses the family from three viewpoints, indicated by the titles of its three sections: (1) concepts of the family; (2) toward a deeper understanding; and (3) treatment. Among the topics of papers in the first section are "Concepts Relevant to Helping the Family As a Group" and "Social Determinants of Family Behaviour"; in the second, "The Normal Family—Myth and Reality," "Chronic Sorrow: A Response to Having a Mentally Defective Child," and "Children at Risk"; and the third, "Treatment in the Home," "Helping a Child Adapt to Stress: The Use of Ego Psychology in Casework," and "Applying Family Diagnosis in Practice."

HERE and THERE



Against poverty

Thirty-six communities have applied to the Office of Economic Opportunity for planning grants of \$10,000 each to develop programs of comprehensive services for families with young children under the pilot program, "parent and child centers," announced by the President last February in his message to Congress on the welfare of children (see CHILDREN, March-April 1967, p. 85). Their plans will focus on helping families living in areas of poverty who have children under 3 years of age meet whatever needs may be interfering with the children's healthy development.

To be approved for operational grants, the plans must be submitted within 6 months after the planning grant has been received and must include built-in methods for evaluating, which are tied into a university in some way. A portion of the funds for Project Head Start has been earmarked for the new program.

The 36 communities were invited to apply on the recommendation of a Federal interdepartmental steering committee representing the Office of Economic Opportunity, the Bureau of the Budget, and three Federal departments—Housing and Urban Development, Labor, and Health, Education, and Welfare. Geographically, they are located in various parts in the United States, from Hawaii to Vermont, and include 22 cities and 10 rural communities. Among the latter are an Indian reservation in South Dakota, a community of agricultural migrants based in Pasco, Wash., and an Eskimo village in Alaska. Fourteen of the cities will develop multiple-service neighborhood centers under another program, and these will be coordinated with the parent and child programs.

The OEO and the cooperating Federal agencies held a 2-week orientation seminar in Washington, D.C., September 11-22, for persons who would be involved in the local planning and in program evaluation. Thirty-one of the thirty-six communities sent such representatives, and a few also sent representatives of the potential users of the services. Also attending the seminar were part-time "project officers," appointed by OEO to give consultation to the communities on both planning and program operation, and members of an HEW consortium—composed of persons from the Children's Bureau (representing the Social and Rehabilitation Service), the Office of Education, and the Public Health Service—which has been working with OEO on the development of program standards. A special feature of the seminar was site visits by small groups to Rochester and Syracuse, N.Y., New York City, and Greensboro, N.C., to see various types of programs for parents and young children, including group day-care and family day-care programs.

. . .

The Ventura County (Calif.) Welfare Department has adopted as a permanent program a work experience and training project that provides work training for mothers receiving assistance under the Aid to Families with Dependent Children (AFDC) program and low-cost day-care service for their children while they are in training. Completely supported for 2 years with Federal funds under the Economic Opportunity Act through the Welfare Administration, U.S. Department of Health, Education, and Welfare, the program now receives State and local support matched by Federal funds under the Social Security Act.

Through two centers, one in Oxnard and the other in the city of Ventura, the project offers mothers in the AFDC program opportunity to obtain basic education; high school equivalency courses; on-the-job training as teacher assistants and general education aides; instruction in child care, the preparation of food, home maintenance, and housekeeping; broad social services to help them solve family problems; and vocational and educational counseling and guidance. Each center provides day-care service for the trainees' children, staffed by other trainees under professional supervision. For this the mothers are charged \$5 a month; the project absorbs the rest of the cost. This low-cost day care is available to the mothers even after they become self-supporting.

During the first 2 years of the program, when it was a Federal project, over 132 mothers took part. Of the 47 completing the course, nearly all have found employment and 23 have been able to withdraw from the AFDC program.

Against smoking

How to protect the public from the health hazards of smoking received the concentrated attention of nearly 500 persons from 30 countries meeting together in New York City on September 11-13, at the World Conference on Smoking and Health.

The conference was held under the auspices of the Interagency Council on Smoking and Health, an association in this country of national voluntary and governmental agencies concerned with the effects of cigarette smoking on health. Its participants included administrators and health educators from governmental and voluntary health agencies; biological and behavioral scientists and science writers; educators; leaders in agencies serving youth; and representatives of the tobacco industry, the press, and the radio and television industries.

Featured speakers outlined congressional proposals for regulating cigarette advertising and the tar and nicotine content of cigarettes; presented research findings showing a higher incidence of morbidity among smokers than nonsmokers; reported on efforts to produce a "safer" cigarette; and discussed ways of helping people, particularly young people, to refrain from smoking.

In 10 work groups the participants focused their attention on various aspects of the smoking problem, including research on how the habit is formed, the responsibility of the media of mass communications, and antismoking programs in school and other ways of influencing young people.

Throughout the conference there was a strong emphasis on the importance of influencing young people against smoking before they start to smoke, on the necessity of getting at the young people through "exemplars," the adults and peers whom they admire.

The American Heart Association has recently issued a leaflet, "What To Tell Your Parents About Smoking," which is being distributed through local heart associations to children and young people through elementary and secondary schools, Girl Scout and Boy Scout groups, 4-H Clubs, church groups, and parent-teacher associations. With the purpose of helping "convince both youngsters and their parents that cigarette smoking is a health menace," the leaflet cites scientific studies pointing to the relation between smoking and heart disease, lung cancer, emphysema, and chronic bronchitis.

Child welfare

The majority of adolescents who run away from suburban homes are responding in a particular way to problems common among adolescents—difficult relations with their parents, their schools, and their peers—according to the findings of a study carried out in Prince Georges County, Md. (adjacent to Washington, D.C.), by the National Institute of Mental Health. For only a small portion of those studied was the running away connected with individual or family pathology.

The investigators gathered data on the social and family characteristics of 631 children aged 10 through 17 who had run away from home in the year ended July 31, 1964, and similar data on a control group of 1,350 students attending 11 local public secondary schools.

The data collected were obtained from police reports on missing persons; in followup interviews with parents and the runaways themselves; from school,

police, and court records; and from questionnaires filled out by the students in the control group. Three-fourths of the runaway children never got beyond the Washington metropolitan area; almost two-thirds were found within 48 hours; half returned home on their own.

Only 52 percent of the runaways lived with both natural parents, as compared with 82 percent of the student respondents. However, over 80 percent of the student respondents reported having trouble at home. About 75 percent of the runaways had conflict within the family, mainly over issues such as the child's school performance, choice of friends, and rejection of family rules and values, according to their parents' reports.

Two-thirds of the runaways had school problems, according to their parents: an equal proportion of the student respondents said they had school problems. School records, however, showed that runaways had more school problems than student respondents. Among the runaways, 58 percent were school dropouts at the time they ran away.

About 40 percent of the runaways belonged to clubs, as compared with 80 percent of the student respondents. Only 50 percent of the runaways had paid employment, as compared with 85 percent of the controls. One out of three runaways had had one or more contacts with the police in the 2 years preceding the missing persons report, according to juvenile bureau records. The same proportion of contacts with police was reported by the control group; but one out of every six runaways had had a charge placed against him, as compared with only one out of 25 in the control group.

Of the runaways, 220 were repeaters. Among the repeaters, 63 percent came from families who had incomes between \$6,000 and \$12,000, as compared with 56 percent of the total group of runaways. In both groups, 28 percent came from families with incomes under \$6,000.

Three-quarters of the repeaters were said by their parents to be having trouble in school, as opposed to one-half of the one-time runaways. School records also showed that repeaters had more school problems than one-time runaways.

The study is reported in detail in a

monograph issued by the Society for Research in Child Development entitled "Suburban Runaways of the 1960's" (available from the University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill. 60637, price: \$3).

The Presbyterian Institute for Human Development, located in Louisville, Ky., recently set up a national child-care information center to collect, store, retrieve, and "package" material on residential group care for children; and the School of Social Work of the University of North Carolina, Chapel Hill, has developed a preliminary system of indexing and processing for the center to use to prepare the most urgently needed material. The first material to be processed will be on group care for dependent and disturbed children and on services to their families provided by public and voluntary child welfare institutions and agencies.

The Child Welfare League of America recently issued a memorandum to its members pointing out that the league "views the development, extension, and improvement of child welfare services for the mentally retarded child and his family" as an appropriate and timely concern for league affiliates. The memorandum points out that only a fraction of the children known to be retarded are receiving child welfare services. It maintains that where such services have been provided by child welfare agencies they have proven to be beneficial, and that providing them has involved only slight adaptation of basic child welfare principles, knowledge, and methods.

Bussing and buses

Children who transfer under a desegregation plan from schools in disadvantaged areas to schools in advantaged areas are still entitled to the special educational benefits offered by title I of the Elementary and Secondary Education Act of 1964 for children from low-income families, according to a policy statement recently sent by the U.S. Commissioner of Education to all chief State school officers. Under title I, schools in designated poverty areas offer children special programs in health, nutrition, and social services;

guidance and counseling; and remedial work. Each school district will work out its own method of having title I programs follow children who transfer from one school to another by plan, the Commissioner's statement points out.

Few schoolbuses adequately protect children from injury or even death in a collision, according to the findings of a study of schoolbus passenger protection made last year by the Institute of Transportation and Traffic Engineering and the Department of Engineering, University of California at Los Angeles, with support from the U.S. Public Health Service and the National Safety Council. The study indicated that the greatest protection for a child in a schoolbus during a collision is a high-strength, high-back safety seat, and that few buses had them.

To gage the safety of schoolbuses and to determine ways to make them safer, the institute staged three accidents by mechanical means involving schoolbuses: two schoolbuses were made to meet head on at 30 m.p.h.; a passenger car traveling at 60 m.p.h. was made to strike a stationary bus from the rear; and a passenger car traveling at 60 m.p.h. was made to strike a stationary bus from the right side. Each bus carried anthropometric dummies of children corresponding to ages 3, 6, and 13, and of adults. After the collisions, the experimenters checked seats, restraint systems, and the performance of the buses and analyzed the effects on the dummies, seat by seat.

The institute's recommendations for improving the safety of schoolbuses include these:

- Seats, in addition to being very strong and having backs at least 28

inches high, should have well-padded armrests and harnesses or lap belts.

- The passenger compartment should be securely attached to the frame of the bus by shear bolts placed at frequent intervals from front to rear and along both seats in a frame.

- Protruding, rigid structures should be eliminated.

- Drivers of schoolbuses should always wear at least a lap-type safety belt when the bus is in motion to insure that they will remain behind the wheel during an accident.

- Buses should have at least four clearly marked exits.

- Schools should conduct emergency exit drills for children who ride schoolbuses to insure quick evacuation, particularly in case of fire.

Nearly 3,700 children were injured in schoolbus accidents in 1965, according to estimates of the study.

READERS' EXCHANGE

Vietnamese Children: *two different views*

The position taken by the Commission on International Social Welfare of the National Association of Social Workers, as reported in the "Here and There" section of the July-August 1967 issue of *CHILDREN* ("Child Welfare," p. 166), regarding war-injured Vietnamese children is regrettable, to say the least.

Let me address myself to three of the four points the Commission made:

1. "The greatest effort should be directed to reuniting children with their own families."

2. "Institutional care of children outside the family should be considered only as a last resort and a temporary measure."

4. "Under no circumstances should children and their needs be used to influence political opinions in regard to United States involvement in Vietnam."

All three of these points may be dismissed. The Committee of Responsibility, Inc. (COR), which has been attempting to bring critically injured

Vietnamese children to this country for treatment, is composed of persons who are willing to set aside their varied personal views on Vietnam in a very real concern for those child victims of the war for whom the expert medical-surgical care needed is simply *not available in Vietnam*.

When confronted with this fact, points one and two are meaningless—as meaningless as though the Commission were to apply them to a severely physically handicapped American child and conclude that the child should remain with his family rather than receive the medical-surgical care he needs, available only at a distant hospital.

Regarding point four, let me assure the Commission that our financial contributions come from both conservatives and liberals.

The one point that is appropriate is three:

3. "Children should only be removed to other countries for needed service in exceptional circumstances, and then all human rights of the children, including the right to return home, must be protected."

This is the exact position of COR.

From July 29 to August 7, two physicians representing COR were in Vietnam to: conclude arrangements with the Minister of Health for evacuation of four war-injured children selected by COR's medical team; and establish a formal basis for a continuing program of case selection and evacuation. Neither of the two goals was achieved, although general principles of operation were agreed upon and a joint communique was issued from the Minister of Health and the COR physicians outlining areas of concurrence.

The failure to achieve immediate success was induced by an evermore complex labyrinth of ministry regulations. The COR doctors were particularly dismayed by these administrative difficulties in view of the needs they witnessed at the six provincial hospitals they visited in I Corps, where much of the recent fighting has occurred.

In these hospitals the load of civilian casualties with amputations, burns, infections, wounds, and fractures of all descriptions precludes any but short range, life-saving care. While the doctors there—American military doctors, European and American volunteers—are dedicated, conscientious, hard working, they cannot meet the need with their inadequate staff and facilities.

COR cannot meet the needs of all

such civilian casualties, for their numbers increase with every increase in the war. However, there are many wounded children for whom a chance to function again could be provided through the skills and technology of the hundreds of U.S. medical specialists and the 20 major medical centers that have volunteered to serve them in the U.S.A.

We have asked the president of the National Association of Social Workers to ask the board of directors of NASW the following question: When an injured Vietnamese child desperately requires treatment *not* available in Vietnam, will NASW support the COR program of transportation to the United States for treatment?

Rex Ragan

Board Member, Los Angeles
Committee of Responsibility, Inc.

A reply

It is to be regretted that Mr. Ragan has chosen to base his comments on out-of-contact excerpts from the letter sent to President Johnson by NASW's Commission on International Social Welfare concerning the care of children in Vietnam. I believe it is important to restate in full all four of the principles "of child welfare as they apply to Vietnamese children and their families" as set forth in the Commission's letter:

"1. All efforts must be made to have every child grow up within his own family as a healthy human being. To this end, greatest and primary emphasis must be placed on keeping or reuniting children with their own, including their extended, families. Families need to be assisted in keeping their children through a vastly extended, improved network of social services and institutions, including if possible a system of family supports (in kind and in money). Institutional care of children outside the family is sometimes necessary to meet immediate needs. However, this kind of child care should be considered as the *last resort* and as a *temporary means only* and should be used to facilitate the reintegration of the child into normal family life.

"2. The efforts of the American social work profession, the American public, and the United States Government should be directed toward strengthening, extending, improving and financing such services in Vietnam. Except in exceptional circumstances children, as a matter of principle, *should not be re-*

moved to other countries to receive needed services. When children are removed from their countries, all of their individual human rights, including the right to return home, must be safeguarded.

"3. To strengthen, expand and improve needed services in Vietnam, the training of professional and semiprofessional personnel is an urgent necessity. Therefore, training programs for such personnel should be vastly and immediately expanded in Vietnam and in this country.

"4. Under no circumstances shall children and their needs be used as means of influencing political opinions concerning our country's involvement in Vietnam."

I cannot dismiss these points as "meaningless" as they relate to the needs of children I observed in a 4-week visit to South Vietnam this past summer. We have an obligation to see that children are not separated from their families or torn from their cultural moorings except as a very last resort. Children in Vietnam need a variety of specialized services. An alternative to bringing a few children to this country to receive these services is to seek to make these services available to them in their own country. Children need their own families, or those who can best substitute for them, especially when they are in need of medical care.

In its letter to the President, the Commission made it clear that "American social workers, like other Americans, differ in their views about this country's involvement in Vietnam, but are united in their deep concern for the plight of the Vietnamese people, and especially their children." The answer to any request to NASW concerning support of any program for children, whether here or abroad, I hope, will be dictated solely by that concern.

James R. Dumpson

Chairman, Commission on
International Social Welfare
National Association of Social Workers

BURNS AND GOODMAN: some questions

The article, "The Teaching Homemaker in a School Project," by Mary E. Burns and Julia Ann Goodman, [CHILDREN, September-October 1967] illustrates the versatility of the many elements in homemaker service. The teaching of better methods of child

rearing and of household management has been an implicit function of this type of service for a long time, but in this experiment of the Highland Park school system's Pupil Adjustment Project, teaching was selected as an explicit function.

The efforts, skill, and imagination of all participants in this thoughtfully designed and professionally well-fortified program converged in helping children from disorganized families and their parents to develop their capacity for achieving social health, thus freeing children to learn and increasing the self-respect of parents and their involvement in the mainstream of educational and social activities.

Recognizing that the description of any project raises more questions than can be answered in one article, I still should like to have learned more about the dynamics of family participation and change in this program. For example, how were the services of the teaching homemakers presented to the families and what were their reactions to having been selected to participate in them? What help was given to the families when situations arose that required other forms of homemaker service? What plans were made for helping families to sustain their gains after the teaching homemakers left the home?

Although casework was the foundation of the program, apparently the homemakers carried out some responsibilities that belonged to the caseworkers such as helping the families in their use of community resources. Since helping families with their needs for other services and their feelings about these needs and motivating them to effectively incorporate these services require casework competence, how was the duplication in responsibilities resolved?

The tangible services of the two teaching homemakers helped to build practical bridges connecting the children and their families with the comprehensive services of the school system. I hope that a detailed report of this creative project will soon be available, for it would undoubtedly provide refreshing topics for staff discussions, seminars, and workshops as well as ideas for planning services.

Nora P. Johnson

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U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

CHILDREN WHO NEED PROTECTION: an annotated bibliography. Compiled by Dorothy M. Jones. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 75 pp. 30 cents.

Lists 463 selected publications on child neglect, most of them published in the last 25 years. The subjects include: child abuse; child welfare; foster home care; homemaker services; juvenile and family courts; maternal deprivation; medical aspects; mental health; parent-child relations; protective services; social casework.

STUDIES IN DELINQUENCY: ALTERNATIVES TO INCARCERATION. LaMar T. Empey. **THE REENTRY OF THE OFFENDER INTO THE COMMUNITY.** Elliot Stndt. **THE CULTURE OF YOUTH.** Marvin E. Wolfgang. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. JD Publication Nos. 9001, 9002, and 9003. 1967. 88 pp., 40 cents; 22 pp., 20 cents; 29 pp., 20 cents, respectively.

The first report analyzes the correctional process and examines efforts con-

cerned with establishing alternatives to incarceration; the second examines the parole process and focuses on conditions affecting the offender's success or failure as a parolee in the community; the third discusses beliefs and standards of young people and their influence on deviant behavior.

HOMEMAKER SERVICE: how it helps children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 443. 1967. 24 pp. 35 cents.

Explains what a homemaker service is, why it is needed, how it is used to help families, and what the development of such a service in a community involves. Includes case histories.

A DEVELOPMENTAL APPROACH TO CASEFINDING WITH SPECIAL REFERENCE TO CEREBRAL PALSY, MENTAL RETARDATION, AND RELATED DISORDERS. Una Haynes. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 449. 1967. 85 pp. \$1.25.

A guide to assist nurses in early rec-

ognition of deviations in normal patterns of growth and development of infants and young children that are symptomatic of anomalies or dysfunctions, especially in the basic neurological reflex patterns and the maturation of the central nervous system. Includes a wheel guide showing normal milestones in development in the first 36 months of life.

"RED IS THE COLOR OF HURTING"—PLANNING FOR CHILDREN IN THE HOSPITAL: based on proceedings of the workshop on mental health planning for pediatric hospitals at the annual meeting of the American Orthopsychiatric Association, New York, April 1965. Milton F. Shore, editor. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health. PHS Publication No. 1583. 1967. 94 pp. 55 cents (paperback).

Contains six papers and discussions ensuing from them on changes needed in hospital pediatric inpatient facilities and in patterns of care to help young children through the stress of short-term hospitalization.

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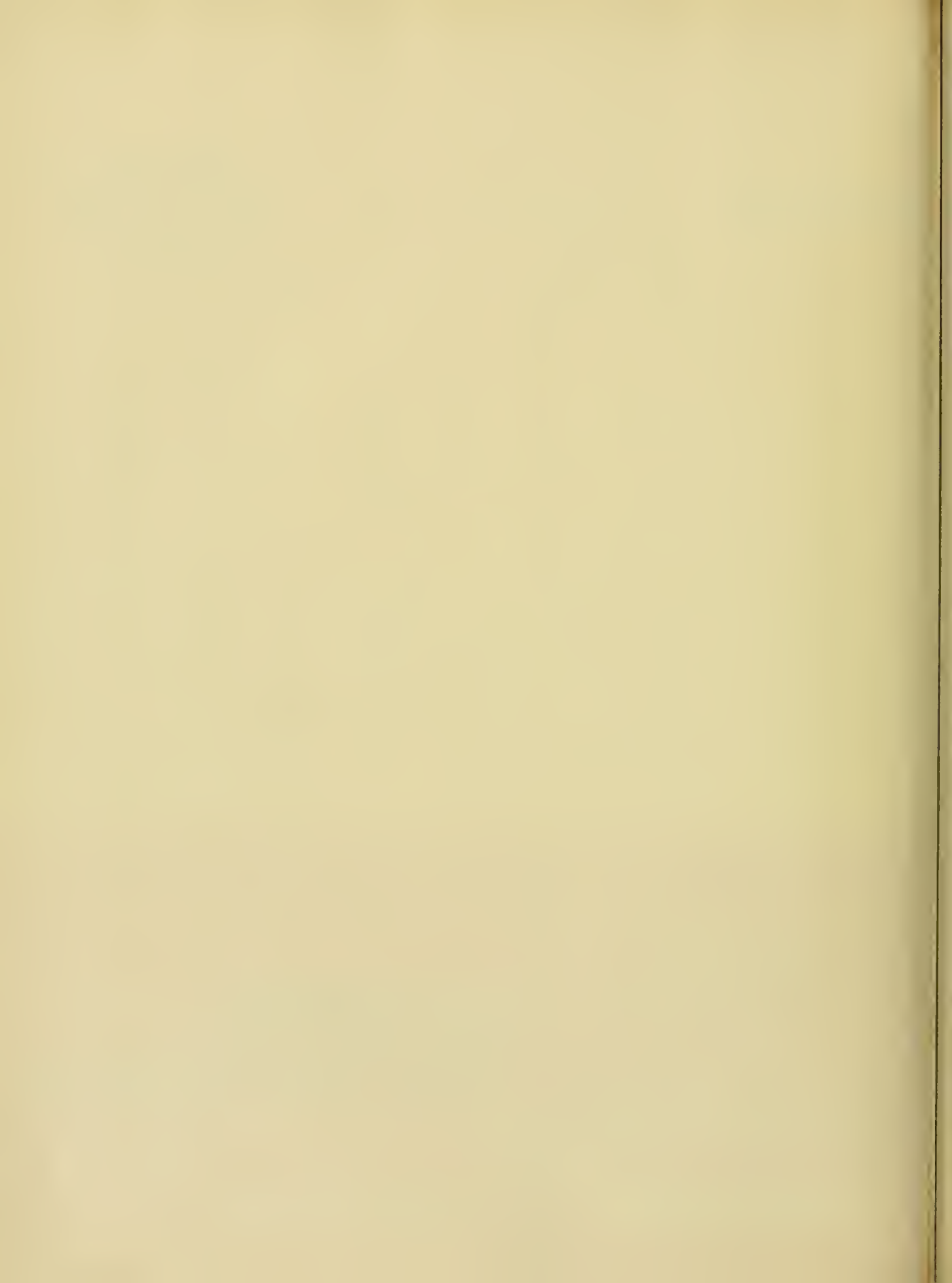
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